DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155637	B. WIN			02/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF F	ROVIDER OR SUPPLIER			6685 E	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
				.000	N/A		
		-	FO	0000	IN/A		
	This visit was for a Recertification and State Licensure Survey.						
	-	ebruary 14, 15,16, 17, 18,					
	21, and 23, 2011						
	Facility number: 001198						
	Provider number: 155637						
	AIM number: 100471000						
	Survey team:						
	Regina Sanders, 1	RN- TC					
	Sheila Sizemore,	RN					
	Kelly Sizemore,	RN					
	Census bed type:						
	SNF: 26						
	SNF/NF: 115						
	Residential: 43						
	Total: 184						
	Census Payor Ty	pe:					
	Medicare: 38						
	Medicaid: 79						
	Other: 67						
	Total: 184						
	-						
	Sample:	24					
	Supplemental sar						
	Residential Samp	-					
		, -					
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC11

Facility ID:

001198

If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUIL B. WING		00	02/23/2		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (VA) ID. SUMMARY STATEMENT OF DEFICIENCIES				6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE		
	findings cited in 16.2.	es also reflect state accordance with 410 IAC completed on February 25, alkner, RN						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC11 Facility ID:

ity ID: 001198

If continuation sheet

Page 2 of 99

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 02/23/2	ETED	
CHICAG	PROVIDER OR SUPPLIER	I VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
F0157 SS=D	resident; consult wand if known, notifice representative or a when there is an a resident which respotential for requiring significant change mental, or psychosocial statuconditions or clinical tertreatment significant conditions or clinical tertreatment significant in the psychosocial statuconditions or clinical tertreatment significations or clinical tertreatment significant readility as specifications. The facility must resident and, if known there is a change in resident state law or regular paragraph (b)(1) or the facility must resident and resident significant resident significant significant change in resident significant change in resident significant si	s in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due uences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or int rights under Federal or ations as specified in	EO	157	F 1571. What is the correctiv	<i>1</i> 0	03/25/2011
	facility failed to on physician was not related to a high resident's review.	review and interview, the ensure a resident's stiffed in a timely manner blood sugar, for 1 of 24 ed for physician total sample of 24.	F0	157	action taken for the resident found to be affected by the deficient practice? a. The Physician was notified relate Resident # 68 elevated blood sugar and no new orders received regarding the report blood sugar.2. How other residents have the potential t	ed to I	03/25/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155637	B. WIN	G		02/23/2011
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SUFFLIER			6685 E	117TH AVE	
	OLAND CHRISTIAN			CROW	N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
TAG	Findings include: 1. Resident #68's record was reviewed on 2/15/11 at 1 p.m. Resident #68's diagnoses included, but were not limited to, diabetes mellitus, arthritis, and neurogenic bladder. A physician's recapitulation orders, dated 2/1/11 through 2/28/11, indicated Accucheck (blood sugar test) two times daily and Novolog (insulin) 100 units/milliliter injection sub-q (subcutaneous) per sliding scale (amount of insulin given based on blood sugar test): < (less than) 60=call MD; 60-150=0 units; 151-200=2 units; 201-250=4 units; 251-300=6 units, 301-350=8 units; 351-400=10 units; > (greater than) 400=12 units and call MD.			TAG	affected by the same deficied practice will be identified and what corrective action will be taken. a. A chart audit was completed on all residents whorders for insulin coverage publicities similarly scale. The Physician notified as indicated. 3. What measures will be put into play what system changes will be made to ensure that the deficities practice does not reoccur a. re-in-service on Physician Notification Policy will be presented to Licensed staff be presented to Licensed staff be presented to Licensed staff on Blood Sugar Policy /Sliding Scale Policy. 4 How the corrective actions whom the corrective actions who monitored to ensure that the deficient practice will not reoile. What quality assurance who put in place a. The medical records staff will audit blood sugar sliding scale documen 3 days a week for one monther statements.	ent I ith er was t ce or cient A A A Color A Color I Color I
	February 2011, in p.m. blood sugar indicated 12 units given and the MI A Medication Re through 2/28/11, (blood sugar test) Novolog (insulin injection sub-q (s	coring Record, dated andicated on 2/14 the 4 result was 461. It is of Novolog insulin was D was not notified. cord, dated 2/1/11 indicated Accucheck two times daily and 100 units/milliliter subcutaneous) per sliding insulin given based on			then weekly for 1 month, even other week for one month and then monthly for 3 months. I medical records staff will replaudit findings to Director of Nursing who will present auditionings to Quality assurance monthly for six month. The quassurance committee will reversifindings monthly for six monthly and will recommend whether monitoring needs to continue	dit e uality riew h

001198

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL			
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NAME OF B	DOLUBED OD GUDDU IED		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF P	PROVIDER OR SUPPLIER			1	117TH AVE			
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROWN POINT, IN46307				
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IAG		< (less than) 60=call	+	IAG			DATE	
		nits; 151-200=2 units;						
	201-250=4 units; 251-300=6 units,							
	· · · · · · · · · · · · · · · · · · ·	351-400=10 units; >						
	•	0=12 units and call MD.						
	The Medication l							
		f the MD being notified						
	of the blood suga	•						
	The resident's record lacked							
	documentation of the MD being notified							
	of the blood suga	ar greater than 400 on						
	02/14/11.							
	A care plan, "Res	sident has Diabetes						
	Mellitus," dated	1/25/11, indicated						
	"Notify MD wi	th any abnormal blood						
	sugar levels"							
	A facility policy	C						
	· ·	d May, 12,2008 and						
		nt by the DoN on 2/17/11						
	· ·	cated "Policy: It is the						
	1 2	ensed staff member will						
	-	ng physicianof change						
	in the resident's c	condition"						
	During an intervi	ew with MDS						
	_	on 2/16/11 at 10:15 a.m.,						
	•	doctor should have been						
		sugar result of 461.						
	nounca or blood	sugai resuit 01 401.						
	3.1-5(a)(2)							
	()(-)							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/23/2011	
CHICAG	PROVIDER OR SUPPLIER	I VILLAGE	6685 E CROWI	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
F0223 SS=A	verbal, sexual, phycorporal punishmens seclusion. The facility must no sexual, or physical punishment, or invalidation of the facility failed to a from abuse from 24 residents reviews ample of 24. (Residents included During an interval a.m., Resident #2 further problems her. She indicated she would tell the and she would tall for her. Resident #22's resident #22	review and interview, the ensure a resident was free a staff member, for 1 of ewed for abuse in a tesident #22)	F0223	F 2231. What is the correct action taken for the resident found to be affected by the deficient practice? a. This self reported abuse allegatic ISDH abuse policy. A report 1/22/11. The staff member, was involved in this incident no longer employed at facili. The resident was reassesses therapy for mode of transfer which was then chat to a two person assist. 2. If other residents have the port to be affected by the same deficient practice will be ide and what corrective action was taken. a. All alert an orient resident were interviewed we further allegation 3. What measures will be put into play what system changes will be made to ensure that the definition prevention re-in-services was presented to staff. c. Services will conduct follow.	was a on per rt sent , who t , is ity b. ed by anged How tential will be red with no ace or e ficient . vice Social

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 02/23/2	LETED	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
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	the facility on 01 An admission M Assessment, date resident could m and could unders mental status sur (moderately imp extensive assista for bed mobility The Resident As dated 01/17/11, in needed assistance mobility and tran A care plan, date resident had a hi a right hip fractu included to trans assistance. A Physical Thera 01/08/11, indicat maximum assista A Nurses' Note, documented, ind notedHead to ta abnormal finding discomfort"	inimum Data Set ed 01/17/11, indicated the ake her self understood stand others, and had a mmary score of 11 aired), and required nce of two or more staff and transfers sessment Protocol report, ndicated the resident e of two staff for bed		interviews to assess resic emotional well being 4. In corrective actions will be monitored to ensure that deficient practice will not i.e. what quality assurance put in place a. The Quality Assurance committee revallegations of abuse mon Recommendations are diand follow-up as needed. an ongoing process.	the reoccur e will be by iews all thly.	

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
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				I	117TH AVE		
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TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		on of rough handling					
	against former C	NA#/.					
	An investigation note, dated 01/22/11						
	An investigation note, dated 01/22/11, indicated an Activities Aide went to the						
		ry (Manager on Duty)					
		r the resident indicated					
		perience with one of the					
		ing. The note from the					
	Director of Dietary indicated, "I went to						
	speak with the resident and she stated that this morning, the girl that came in to help						
		egir that came in to help herThe aide told her to					
		ast and the resident stated					
	_	to do that and the aide					
		ld stand by her self (sic)					
		ny help. Resident got					
	_	positionand then held					
		shed her hand off her					
		shed her hand off her as afraid of falling"					
	aim. Resident wa	as arraid or raining					
	An investigation	note, dated 01/22/11 at					
	I -	ted the Nurse Manager					
	1 * '	esident and the resident					
	1 ^	: CNA #7 as the CNA					
		Ther that morning. The					
		rmer CNA #7 was					
	removed from th						
		ident had told CNA #7					
		nd and the CNA had told					
		he note indicated the					
		I could tell she didn't					
	· ·	cause she made a face,					
	want too (SIC) be	cause site made a fact,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155637	B. WINC			02/23/2	011
NAME OF I	PROVIDER OR SUPPLIER		·		DDRESS, CITY, STATE, ZIP CODE		
					117TH AVE		
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TAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
		with my thingswhen it					
	1	n to the wheel chair (sic)					
		said ok (resident name)					
	_	placed a hand under my					
		me up to a stand. It was					
		es gave out and I grabbed					
	, ,	support. She yelled at me					
		oped my hand off of her.					
		to quickly sit in the wheel					
	` ′	was so afraid I was going					
	to fall and brake	(sic) my hip again"					
	Am improstication	mata datad 01/22/11 at					
	_	note, dated 01/22/11 at					
		mer CNA #7, indicated,					
	_	to get dress (sic) and up					
		wheelchair at 11:00					
		to stand up (arrow up)					
		her I would be right here					
		as standing on her left					
		ny left arm underneath					
		on the count of 3 we are					
		(arrow up). I counted to					
		ıp (arrow up). As I was					
	1	up (arrow up), she was					
	1 -	y uniform, extremely					
	1 -	lifficult for me to assist					
	,	ent name) she is going to					
	have to let go of	my uniform, I never					
	slapped, shoved,	pushed or grabbed her					
	hand at any poin	t"					
	_	nvestigation, dated					
	01/27/11, indicat						
	investigation it v	vas determined that there					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	was no intent but to have some em immediately afte Nursing Aide is a facility. An abuse A Social Service 9:45 a.m., indicate verbalized her count and the care. The resident was come A facility policy, Protocol for Abu 09/08, and receive Director as curre policy of this fac	the resident did appear otional stress r incidentCertified no longer employed at e in-service is underway." note, dated 01/26/11 at ted the resident had oncern about the CNA e note indicated the infortable and calm. titled, "Community se Prevention", dated yed from the Executive nt, indicated, "It is the illity that each resident (sic) be subjected to		- 1	CROSS-REFERENCED TO THE APPROPRIAT	TE TO THE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY		
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CHICAG	OLAND CHRISTIAN	1 VILLAGE	I	N POINT, IN46307	
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TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0225 SS=D	have been found of or mistreating resistance had a finding nurse aide registry mistreatment of resistreatment of their property; a has of actions by a employee, which we service as a nurse the State nurse aid	not employ individuals who guilty of abusing, neglecting, dents by a court of law; or gentered into the State y concerning abuse, neglect, esidents or misappropriation and report any knowledge it a court of law against an would indicate unfitness for eaide or other facility staff to de registry or licensing			
	violations involving abuse, including ir and misappropriat reported immediat the facility and to with State law through	ensure that all alleged g mistreatment, neglect, or njuries of unknown source tion of resident property are tely to the administrator of other officials in accordance ough established procedures state survey and certification			
	alleged violations	nave evidence that all are thoroughly investigated, further potential abuse while in progress.			
	reported to the adding representative and accordance with Sistate survey and working days of the	nvestigations must be ministrator or his designated d to other officials in State law (including to the certification agency) within 5 he incident, and if the alleged d appropriate corrective sen.			
	interview, the fac investigate and re Department of H	ation, record review, and cility failed to thoroughly eport to the Indiana State lealth, an injury of related to multiple	F0225	F 2251. What is the correcti action taken for the resident found to be affected by the deficient practice? a. A hear toe assessment was comple on Resident #120 and it was	d to

001198

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	bruising found on 1 of 24 residents				determined there was no furt		
	reviewed for inju	iries of unknown origin			injury related to previous inci of multiple bruising. b. The fa		
	in a sample of 24	1. (Resident #120)			committee will re-evaluate	uı	
					resident # 120 to determine		
	Findings include:				safety issues and		
					precautions. c. The care plar	ı will	
	Resident #120's	record was reviewed on			be reviewed and updated rel		
		o.m. Resident #120's			to falls ,syncope, dementia a	and	
	_				toileting program will be assessed d. Social services	will	
	"	ed, but were not limited			meet with family to initiate ca		
		zure disorder, and			plan intervention related to fa		
	arthritis.				and declining dementia in ord		
					manage safety issues. 2. Ho		
	A quarterly MDS	S (Minimum Data Set)			other residents have the pote	ential	
	assessment, date	d 11/12/10, indicated			to be affected by the same	4:C - J	
	Resident #120 w	as cognitively impaired			deficient practice will be iden and what corrective action w		
	and required ext	ensive assist for transfer,			taken. a. All residents will be		
	ambulation, and	dressing. The assessment			reassessed to determine if		
		ident had previous falls in			bruising and or skin issues a		
	the facility.	r			evident .Any bruising and or	skin	
					issues will be reported to attending physician and ISDI	⊒ if	
	Δ Nurses' Note	dated 12/1/10 at 1:45			appropriate. 3. What measu		
	1	Summonsed to room c/			will be put into place or what		
	1 *	esident's alarm. Res			system changes will be made		
	1 ` ′	on bathroom floor in			ensure that the deficient prac		
	` ′				does not reoccur a. Staff wil		
		ng upright on buttocks c/			re-in-service on facility policion and procedures on thorough		
	1 ` ′	in front of her right past			investigating and reporting of	-	
	1	yay. Res reports she had			injuries of unknown origin. S		
		et. Denies c/o (complaint			will also be re-in-service to		
	1 /	of motion) wnl (within			include initiating and complet	ting	
	normal limits) to all ex (extremities)no				facility incident and accident		
	evidence of injur	ry noted"			report. 4. How the corrective actions will be monitored to	,	
					ensure that the deficient pra	ctice	
	A Nurses' Note,	dated 12/1/10 at 7:00			will not reoccur i.e. what qua		
	p.m., indicated "	No injuries noted			assurance will be put in place	e a.	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
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		155637	B. WIN	IG		02/23/2011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			6685 E	117TH AVE	
	OLAND CHRISTIAN			CROW	N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	, ,	DATE
	post-fall. No brui	ısıng"			RCC/Designee will review Incident /Accident Report for	
	Nurses' Notes, dated 12/2/10 at 12 noon				completeness, witness	
					statements, and detemined a	an
	and 7:00 p.m., "	No injuries noted"			investigation has been	
					initiated/and or completed. b	
	A Nurses' Note, o	dated 12/3/10 at 5:00			Incidents /Accidents will be	
	a.m., indicated ".	o/ evidence of injury"			reviewed at the morning clini meeting and it will be determ	
		3 3			by Director of Nursing	iiiled
	Nurses' Notes, dated 12/3/10 at 11:00 a.m. and 9:30 p.m., indicated the resident had				/Administrator if further action	n l
					required. c. Director of Nurs	ı
	no injury.	dicated the resident had			/Designee will report	
	ino mjury.				Incident/Accident findings to	
	A Nurses' Note, dated 12/4/10 at 11:00				monthly and this will be ongo	ping.
	· ·					
	· ·	o injuries from the				
	previous fall.					
	A Nurses' Note	dated 12/7/10 at 1:15				
	· ·	Skin assessment: skin				
	l '					
	1 ` *	ouch. Pink color, no skin				
	tears, no pressure	e sites."				
	A Nurses' Notes	dated 12/14/10 at 7:00				
	a.m., indicated "					
	l '	Ier skin assessment				
		ultiple R (right) hip 9 x				
	l · • ·	neters) greenish/purple.				
	· ·	(sic) thigh green bruise 3				
	cm x 2 cm. R inn					
		ees 3 x 3 cm green				
		outer leg 2 cm x 2 cm				
	green bruise. L (l	eft) shin 8 cm wide 6 cm				
	long pale green b	oruise L lower leg 3 cm				
	circle bruise. Wh	en resident asked where				
	they came from s	she stated she fell"				

001198

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155637	B. WIN			02/23/20	11
NAME OF I	DROVIDED OD GUDDI IED		!		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			6685 E	117TH AVE		
	OLAND CHRISTIAN				N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	\	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	те	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)	+	DATE
	1	s after the resident fell on					
	12/1/10.						
	The Skin and Shower Sheets, dated						
		nuary 2011, lacked					
		f Resident #120 having					
	any bruises.						
	During an interview on 2/16/11 at 4:40 p.m., LPN #10 indicated the CNAs are						
	supposed to document areas found on the resident "like bruises" on the Skin and Shower Sheets.						
	The Investigation	n Conclusion Form, dated					
	12/1/10, indicate	d the resident did not					
	receive any injur	ies from the fall.					
	A form, dated 12	/14/11 at 1:15 a.m.,					
	provided by the	ADoN (Assistant Director					
	of Nursing) on 2	/17/11 at 2:15 p.m., titled					
	"Accident Incide	nt Report" indicated the					
	bruising on the re	esident was found during					
	rounds by the nu	rse. The form indicated					
	1 **	he facility asked had not					
	been taking care	•					
	Resident #120 w	as observed on 2/16/11 at					
	3:55 p.m. CNA	#6 was assisting the					
		throom. The resident					
		have very faint green					
		ght hip and the thigh.					
	_						
		d she was off the day the IA #6 indicated the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		(X2) MU: A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 02/23/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	p. white	STREET A	DDRESS, CITY, STATE, ZIP CODE		
	OLAND CHRISTIAN				117TH AVE N POINT, IN46307		
(X4) ID	_	TATEMENT OF DEFICIENCIES		ID	·		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident nad falle	en twice that week.					
	p.m., the Eden U	ew on 2/16/11 at 3:20 Init Manager indicated the ative skin assessment rses' notes.					
	During an intervent p.m., the Restoratesident did not be she fell on 12/1/2 the resident's bruck Nurse indicated resident acquired During an intervent p.m., the Restoratesident acquired facility could not occurrence for 12 During an intervent p.m., RN #4 indicates the resident acquired p.m., the Restoratesident acquired facility could not occurrence for 12 puring an intervent p.m., RN #4 indicates the resident p.m., RN #4 indicates the resident p.m., the Restorates the resident p.m.	iew on 2/16/11 at 3:25 ative Nurse indicated the have any bruising when 10. When asked about using the Restorative she did know how the 1 the bruising. iew on 2/16/11 at 3:40 ative Nurse indicated the t find an unusual 2/14/11. iew on 2/17/11 at 10:05 cated she was the nurse					
	on 12/14/10. RN know how the bring resident had falle worked the midnum "see the resident arms." RN #4 in why the CNAs d	ruises on Resident #120 If #4 indicated she did not ruising occurred or if the en. RN #4 indicated she hight shift and does not so below the waist, just the adicated she did not know id not report the eng. RN #4 indicated she					
	had filled out an management cou	incident report but Ild not find it and had just to her about it. RN #4					

NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUIST BE PERCEDED BY FILL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) MPLETION DATE
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	MPLETION
CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION	MPLETION
PROVIDER'S PLAN OF CORRECTION	MPLETION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
indicated the bruises had looked like the resident had "bumped everything in the	
bathroom." RN #4 indicated the resident	
would not be able to get up on her own if	
she fell.	
During an interview on 2/17/11 at 2:10	
p.m., the ADoN indicated there was only	
one witness statement. The ADoN indicated the incident had not been	
investigated nor reported to the Indiana	
State Department of Health.	
3.1-28(d)	
F0226 The facility must develop and implement SS=D written policies and procedures that prohibit	
mistreatment, neglect, and abuse of residents and misappropriation of resident property.	
Based on observation, record review and F0226 F2261. What is the corrective 03/	/25/2011
interview, the facility failed to follow the action taken for the resident found to be affected by the	
facility's policy for investigating and reporting to the Indiana State Department facility's policy for investigating and deficient practice? a. A head to toe assessment was completed	
of Health an unusual occurrence related to of Health an unusual occurrence related to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 02/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE CROWN POINT, IN46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE injuries of unknown origin for 1 of 24 determined there was no further injury related to previous incident residents reviewed for injuries of of multiple bruising. b. A unknown origin in a sample of 24 Complete an thorough residents. (Resident #120) investigation related to injury of unknown origin will be submitted to ISDH c. The fall committee will Findings include: re-evaluate resident # 120 to determine safety issues and A facility policy titled "Accidents and precautions. d. The care plan Incidents," dated 2/10, indicated will be reviewed and updated related to falls, syncope, "Investigation Process: All incidents dementia and toileting program require a thorough investigation in an will be assessed e. Social attempt to determine what occurred and to services will meet with family to make changes as needed to prevent initiate care plan intervention related to falls and declining reoccurrence...The investigation seeks to dementia in order to manage determine if and how abuse, neglect, safety issues. 2. How other negligent treatment, exploitation, or residents have the potential to be affected by the same deficient misappropriation of resident property practice will be identified and occurred...Reporting to State Regulatory what corrective action will be Agency: ...2. When an incident /accident taken. a. All residents will be is reportable, initial notification to public reassessed to determine if health will be made within 24 hours of the bruising and or skin issues are evident .Any bruising and or skin incident/accident " issues will be reported to attending physician and ISDH if Resident #120's record was reviewed on appropriate. 3. What measures 2/16/11 at 2:35 p.m. Resident #120's will be put into place or what system changes will be made to diagnoses included, but were not limited ensure that the deficient practice to, dementia, seizure disorder, and does not reoccur a. Staff will be arthritis. re-in-service on facility policies and procedures on thoroughly investigating and reporting on A quarterly MDS (Minimum Data Set) injuries of unknown origin. Staff assessment, dated 11/12/10, indicated will also be re-in-service to Resident #120 was cognitively impaired include initiating and completing and required extensive assist for transfer, facility incident and accident report. 4. How the corrective ambulation, and dressing. The assessment

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED		
		155637	B. WIN			02/23/20	011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	PROVIDER OR SUPPLIER			1					
0111040	OLAND OLIDIOTIAN	11/11/14/05			117TH AVE				
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROW	N POINT, IN46307				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re I	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	indicated the resi	ident had previous falls in			actions will be monitored to				
	the facility.	•		ensure that the deficient practice					
	A Nurses' Note, dated 12/1/10 at 1:45			will not reoccur i.e. what quality					
					assurance will be put in place	e a.			
	· ·				RCC/Designee will review				
	* ·	Summonsed to room c/			Incident /Accident Report for				
	l ` ′	esident's alarm. Res			completeness, witness statements, and investigation	hae			
	(resident) found on bathroom floor in front of sink sitting upright on buttocks c/w/c (wheelchair) in front of her right past bathroom entryway. Res reports she had				been initiates/and or complete				
					b. Incidents /Accidents will b				
					reviewed at morning clinical				
					meeting and it will be determ	ined			
	taken self to toilet. Denies c/o (complaint				by Director of Nursing				
	of), rom (range of motion) wnl (within				/Administrator if further action				
					required. c. Director of Nurs	ing			
	l '	all ex (extremities)no			/Designee will report	<u> </u>			
	evidence of injur	y noted"			Incident/Accident findings to				
					monthly and this will be ong	oing.			
	A Nurses' Note.	dated 12/1/10 at 7:00							
	· ·	No injuries noted							
	* ·	•							
	post-fall. No bru	ising							
	l '	ated 12/2/10 at 12 noon							
	and 7:00 p.m., ".	No injuries noted"							
	A Nurses' Note.	dated 12/3/10 at 5:00							
	· ·	o/ evidence of injury"							
		Criacines of injury							
	Nurgas! Natas d	atad 12/2/10 at 11:00 a m							
	· ·	ated 12/3/10 at 11:00 a.m.							
	_	dicated the resident had							
	no injury.								
	A Nurses' Note,	dated 12/4/10 at 11:00							
	1	o injuries from the							
	previous fall.	y							
	previous rail.								
		1 . 110/7/10 1 15							
	A Nurses' Note, o	dated 12/7/10 at 1:15							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
ANDILAN	or connection	155637		LDING	00	02/23/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
mo		Skin assessment: skin		1110			DITTE
	ĺ	couch. Pink color, no skin					
	tears, no pressure						
	_						
	· ·	dated 12/14/10 at 7:00					
	a.m., indicated "The resident fell						
		er skin assessment shows					
	bruises, multiple R (right) hip 9 x (by) 9 cm (centimeters) greenish/purple. Bruise, R outter (sic) thigh green bruise 3 cm x 2 cm. R inner thigh prox (proximately) knees 3 x 3 cm green bruise. R lower						
	outer leg 2 cm x 2 cm green bruise. L						
	(left) shin 8 cm v	vide 6 cm long pale green					
	bruise L lower le	g 3 cm circle bruise.					
		sked where they came					
		he fell" This was 14					
	days after the res	sident fell on 12/1/10.					
	The Skin and Sh	ower Sheets, dated					
		nuary 2011, lacked					
		f Resident #120 having					
	any bruises.						
	•	iew on 2/16/11 at 4:40					
		ndicated the CNA's are ment areas found on the					
		nent areas found on the lises" on the Skin and					
	Shower Sheets.	noco un uic orin anu					
	Shower Sheets.						
	The Investigation	n Conclusion Form, dated					
	12/1/10, indicate	d the resident did not					
	receive any injur	ies from the fall.					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MU: A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 02/23/2	ETED
	PROVIDER OR SUPPLIER		B. WING	STREET A 6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	A form, dated 12 provided by the A of Nursing) on 2. "Accident Incide bruising on the recount of Nursing of Nursing to the recount of Nursing to the recount of Nursing an interview of Nursing of Nursi	ADON (Assistant Director /17/11 at 2:15 p.m., titled nt Report" indicated the esident was found during rse. The form indicated he facility asked had not of the resident. as observed on 2/16/11 at 46 was assisting the atthroom. The resident have very faint green ght hip and the thigh. d she was off the day the IA #6 indicated the entwice that week. Ew on 2/16/11 at 3:20 init Manager indicated the tive skin assessment rses' notes. See word 2/16/11 at 3:25 itive Nurse indicated the nave any bruising when 10. When asked about ising the Restorative she did know how the 1 the bruising.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUILDIN		NSTRUCTION 00	(X3) DATE S COMPL 02/23/2	ETED
	PROVIDER OR SUPPLIER		66	85 E 1	DDRESS, CITY, STATE, ZIP CODE 117TH AVE I POINT, IN46307		
CHICAG (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR OCCURRENCE for 12 During an intervia.m., RN #4 individed in the brown of the brown	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 2/14/11. Tew on 2/17/11 at 10:05 cated she was the nurse ruises on Resident #120 I #4 indicated she did not ruising occurred or if the en. RN #4 indicated she right shift and does not s below the waist, just the dicated she did not know		ROWN		TE .	(X5) COMPLETION DATE

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155637	B. WING		02/23/2011
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0272 SS=E	The facility must operiodically a comstandardized representation of a reach resident's fur. A facility must make assessment of a reach resident's fur. A facility must make assessment of a reach resident's fur. RAI specified by the must include at lead Identification and of Customary routine Cognitive patterns Communication; Vision; Mood and behavior Psychosocial well-Physical functioning Continence; Disease diagnosist Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentiated Documentation of regarding the additional performed through protocols; and Documentation of Based on observation interview, the fact assessments were related to bruising bladder, and a PI	onduct initially and prehensive, accurate, oducible assessment of nctional capacity. Re a comprehensive esident's needs, using the ne State. The assessment ast the following: demographic information; es; or patterns; being; ng and structural problems; and health conditions; and status;	F0272	F 2721. What is the corrective action taken for the resident found to be affected by the deficient practice? a. A heatoe assessment was completed on resident #120.The assessment indicated that the	ve 03/25/2011 d to ted
	reviewed for con	nplete and accurate sample of 24 residents.		resident had no further bruisi This assessment has been documented in the nurses no	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155637	B. WIN			02/23/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				117TH AVE		
CHICAC	OLAND CHRISTIAN	LVILLAGE		1	N POINT, IN46307		
CHICAG	OLAND CHRISTIAN	VILLAGE		CROW	N POINT, IN40307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5))
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	ΓΙΟΝ
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	(Resident #22, #2	23, #38, and #120)			and the resident care plan a	nd	
		,			aide care record have been		
	Findings include				updated .b. The PICC site f	or	
					resident # 23 was assessed		
					following facility policy and		
		o's record was reviewed			procedure. The findings of the		
	on 2/16/11 at 2:3	5 p.m. Resident #120's			assessment were document		
	diagnoses includ	ed, but were not limited			resident clinical record. Resi care plan and aide care reco		
	~	zure disorder, and			sheet have been updated. c.		
	arthritis.				fall assessment for resident		
	artificis.				was reviewed and updated to		
	, 1 MDC				indicate residents current fal		
	A quarterly MDS (Minimum Data Set) assessment, dated 11/12/10, indicated				status .Residents care plan a	ınd	
					aide care record sheet have	been	
	Resident #120 w	as cognitively impaired			updated. d. Resident #22 i		
	and required exte	ensive assist for transfer,			fall assessment for resident		
	1	dressing. The assessment			was reviewed and corrected		
	· ·	dent had previous falls in			reflect the residents current to	all	
		dent had previous fans in			status. Resident fall risk assessment indicates reside	at io	
	the facility.				at high risk for falls with a sc		
					of 12. The care plan and aid		
	A Nurses' Note, o	dated 12/1/10 at 1:45			assignment sheet have beer		
	p.m., indicated "S	Summonsed to room c/			updated to reflect residents		
	(with) CNA by re	esident's alarm. Res			current fall status. ii. Resid	ent#	
	(resident) found	on bathroom floor in			22 was reassessed related to		
	l ` ′	ng upright on buttocks c/			contingency on 2/16/11 and		
					documented on urinary		
	l ` ` ′	in front of her right past			assessment form. 2. How of		
	1	ray. Res reports she had			residents have the potential		
		et. Denies c/o (complaint			affected by the same deficient practice will be identified and		
	of), rom (range o	f motion) wnl (within			what corrective action will be		
	normal limits) to	all ex (extremities)no			taken. a. All residents will be		
	evidence of injur	y noted"			reassessed for skin issues, f		
		-			and incontinence. Findings v		
	A Nurged' Note	dated 12/1/10 at 7:00			documented in medical reco	rd,	
	· ·				care plan and aide care reco		
	* ·	No injuries noted			sheets will updated as need		
	post-fall. No brui	ısıng"			b. All resident with PICC line		
					be reassessed per facility PI		

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155637	B. WIN			02/23/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	-	
0111040	OLAND OUDIOTIAL	N1./// 1.4.05		1	117TH AVE		
CHICAG	OLAND CHRISTIAI	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	-	TAG		dia a a	DATE
	1	ated 12/2/10 at 12 noon			policy and procedure and fin documented in the medical	aings	
	and 7:00 p.m., "No injuries noted"				record. 3. What measures w	vill be	
					put into place or what systen		
	A Nurses' Note,	dated 12/3/10 at 5:00			changes will be made to ens		
	a.m., indicated "	o/ evidence of injury"			that the deficient practice do		
					not reoccur a. MDS team wi re-in-serviced with emphasis		
	Nurses' Notes, d	ated 12/3/10 at 11:00 a.m.			i. Assessment Protocol ii.	OII	
	and 9:30 p.m., ir	ndicated the resident had			Accuracy and completeness	of	
	no injury.				assessment iii. Care Plan//	Aide	
					care record 1. Initiate /updat	es	
	A Nurses' Note, dated 12/4/10 at 11:00				Complete /Accurate b. Licensed nurses will be		
	1	o injuries fro the previous			re-in-service on PICC protoc	ol 4	
	fall.	3			How the corrective actions w		
				monitored to ensure that the			
	A Nurses' Note	dated 12/7/10 at 1:15			deficient practice will not reo		
	1	Skin assessment: skin			i.e. what quality assurance w put in place a. All MDS/Care		
	1	touch. Pink color, no skin			plans that are scheduled be		
	tears, no pressur				completed during month will	be	
	tears, no pressur	e sites.			audited by consultant nurse		
	A Nurgas! Notas	, dated 12/14/10 at 7:00			/designee monthly for six mo	nths.	
	1				Findings will be reviewed by Director of Nursing who will I	oport	
	a.m., indicated "				to Q/A if trends are identified		
		ler skin assessment shows			audits will be ongoing until		
	1	R (right) hip 9 x (by) 9			compliance is reached.		
	1 '	greenish/purple. Bruise,					
	1 ' '	gh green bruise 3 cm x 2					
	1	h prox (proximately)					
	1	green bruise. R lower					
	1	2 cm green bruise. L					
	(left) shin 8 cm	wide 6 cm long pale green					
	bruise L lower le	eg 3 cm circle bruise.					
	When resident a	sked where they came					
	from she stated s	she fell" This was 14					
	days after the res	sident fell on 12/1/10. A					
	1 -	n indication of an					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE : COMPL	
AND TEAN	or conduction	155637	- 1	LDING		02/23/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROWN	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
IAU	older/healing bru	·		IAG			DATE
	older/ficaling of	iisc.					
	A Professional R	esource Website					
	"www.nlm.nih.gov" (National Library of						
		ational Institute of					
	Health), titled, "I	Bruise Mark Treatment",					
	·	cated, "The bruise will					
	change color from	n red to purple to yellow					
	to brown before disappearing"						
	The Skin and Shower Sheets, dated						
	December and January 2011, lacked						
	documentation of Resident #120 having						
	any bruises.						
	The Investigation	n Conclusion Form, dated					
		d the resident did not					
	receive any injur						
	Teeerve arry mjur	ies nom me ian.					
	Resident #120 w	as observed on 2/16/11 at					
	#:55 p.m. CNA	#6 was assisting the					
	resident to the ba	throom. The resident					
	was observed to	have very faint green					
	bruising to the rig	ght hip and the thigh.					
	CNA #6 indicate	d she was off the day the					
	resident fell. CN	A #6 indicated the					
	resident had falle	en twice that week.					
		0/1/2/11 - : 2/20					
	~	ew on 2/16/11 at 3:20					
	_	nit Manager indicated					
		why the bruises were					
		in the skin assessments.					
		fanager indicated the					
	nurses do a narra	tive skin assessment					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE 00 COMPLETED					
AND PLAN	OF CORRECTION	155637	A. BUILD	DING	00	02/23/2	
		100007	B. WING	CTD FFT A	DDDFGG CITY CTATE ZID CODE	OZ/ZO/Z	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	I VILLAGE			N POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1 '	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	weekly in the nur	rses' notes.					
	.	0/1///11 + 0.05					
	1	iew on 2/16/11 at 3:25					
	l * ·	tive Nurse indicated the					
		nave any bruising when					
		0. When asked about					
	the resident's bruising the Restorative						
	Nurse indicated she did not know how the						
	resident acquired the bruising.						
	During an interview on 02/16/11 at 3:35						
	p.m., the Restorative Nurse indicated a						
	1 *	an old bruise. She					
	~	not think the bruises					
	were from the fal						
		ervation on 02/15/11 at 9					
	I -	23 was sitting in a					
		room. There was a					
		d in the resident's left					
	arm.						
	Resident #23's re	ecord was reviewed on					
	02/15/11 at 11 a.1	m. The resident's					
	diagnoses includ	ed, but were not limited					
	to, renal insuffici	ency and Parkinson's					
	Disease.						
	· ·	capitulation order, dated					
	· ·	the resident had a PICC					
		m since 12/10/10 and the					
	· -	ange the dressing on the					
	PICC line every	seven days.					
	A Physician's Or	der, dated 01/28/11,					
	111 11951010111 5 01	aci, autoa 01/20/11,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED				
		155637	B. WING 02/23/2011				
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			6685 E	117TH AVE		
	OLAND CHRISTIAN				N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		er for Zosyn (antibiotic),					
	to be administered by the PICC line every						
	six hours.						
	The median de To						
	The resident's Treatment Administration						
	\ ''	ated 01/11, indicated the					
		ine was flushed daily for					
	maintenance.						
	The resident's TAR and Medication Administration Records (MAR), dated						
	1	and the Nurses' Notes,					
		nrough 02/15/11, lacked					
		o indicate the PICC line,					
		erence, and the PICC line					
		d been assessed as					
	indicated in the f	facility policy.					
	During an interview	on 02/15/11 at 1:05 p.m.,					
	_	ere was no documentation to					
	indicate the PICC lin	ne had been assessed.					
	A facility policy do	ted 03/07, titled, "Peripherally					
		heter (PICC) Dressing					
		from the Director of Nursing as					
	current, indicated, "	5. Assessment of venous					
	_	med: 5.1 During dressing					
		e and after administration of					
		Assessment is to include, but					
		absence or presence of: 6.1					
	erythema, 6.2 Drain	-					
	1 -	nge in skin temperature, 6.5					
	Tenderness at the sit	te or along vein tract, 6.6					
		ent dressing. 7. Length of					
		upper arm circumferenceis					
	ootained:/.2 Durii	ng dressing changes"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE : COMPL	ETED
	155637	- 1	G		02/23/2	011
ROVIDER OR SUPPLIER			1			
LAND CHRISTIAN	I VILLAGE		1			
			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
`			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
3. Resident #38's re 02/17/11 at 10:45 a.i included, but were in hypertension. The resident's, Fall H 10/26/10, 01/04/11, indicated the resident months. The resident's Nurse through 02/17/11, la indicate the resident During an interview Reclaim Unit Manag not had a fall since 0 fall assessment was: 4. Resident #22's re 02/16/11 at 9:10 a.m included, but were in post right hip fractur into the facility on 0 A) The Fall Risk Assindicated the resident (Lopressor), a diuret (Oxycontin) and the was three and the resident score on the Fa (total score of 10 or for falls). The Fall Risk Assess takes three to four or resident's score wou resident's fracture were sident's fracture wer	cord was reviewed on m. The resident's diagnoses of limited to dementia and Clisk Assessment, dated 01/21/11, and 02/03/11, at had fallen in the past three s' Notes, dated 01/04/11 cked documentation to had a fall. on 02/17/11 at 10:50 a.m., the ger, indicated the resident had 04/06/10. She indicated the not correct. cord was reviewed on a. The resident's diagnoses of limited to, hypertension and re. The resident was admitted 1/07/11. sessment, dated 01/07/11, at was on an antihypertensive sic (Lasix), and a narcotic score for the medication area sident had no fractures. The ll Risk Assessment was 9 above represents a high risk sment indicated if the resident f the medications, the ld be a four, and if the ould have been marked, the		IAG	DEPILIENCI		DATE
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR 3. Resident #38's re 02/17/11 at 10:45 a.mincluded, but were in hypertension. The resident's, Fall I 10/26/10, 01/04/11, indicated the resident months. The resident's Nurse through 02/17/11, la indicate the resident months. The resident's Nurse through 02/17/11, la indicate the resident months. A. Resident #22's re 02/16/11 at 9:10 a.mincluded, but were in post right hip fracture into the facility on 0 A) The Fall Risk As indicated the resident (Lopressor), a diuret (Oxycontin) and the was three and the resident score on the Fall total score of 10 or for falls). The Fall Risk Assess takes three to four or resident's score wou resident's fracture were resident.	DENTIFICATION NUMBER: 155637 ROVIDER OR SUPPLIER BLAND CHRISTIAN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3. Resident #38's record was reviewed on 02/17/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension. The resident's, Fall Risk Assessment, dated 10/26/10, 01/04/11, 01/21/11, and 02/03/11, indicated the resident had fallen in the past three months. The resident's Nurses' Notes, dated 01/04/11 through 02/17/11, lacked documentation to indicate the resident had a fall. During an interview on 02/17/11 at 10:50 a.m., the Reclaim Unit Manager, indicated the resident had not had a fall since 04/06/10. She indicated the fall assessment was not correct. 4. Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was admitted into the facility on 01/07/11. A) The Fall Risk Assessment, dated 01/07/11, indicated the resident was on an antihypertensive (Lopressor), a diuretic (Lasix), and a narcotic (Oxycontin) and the score for the medication area was three and the resident had no fractures. The total score on the Fall Risk Assessment was 9 (total score of 10 or above represents a high risk	DENTIFICATION NUMBER: 155637 A. BUI B. WIN ROVIDER OR SUPPLIER DIAND CHRISTIAN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3. Resident #38's record was reviewed on 02/17/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension. The resident's, Fall Risk Assessment, dated 10/26/10, 01/04/11, 01/21/11, and 02/03/11, indicated the resident had fallen in the past three months. The resident's Nurses' Notes, dated 01/04/11 through 02/17/11, lacked documentation to indicate the resident had a fall. 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The Fall Risk Assessment indicated if the resident takes three to four of the medications, the resident's score would be a four, and if the resident's fracture would have been marked, the	TOVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 3. Resident #38's record was reviewed on 02/17/11 at 10:45 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension. The resident's, Fall Risk Assessment, dated 10/26/10, 01/04/11, 01/21/11, and 02/03/11, indicated the resident had fallen in the past three months. The resident's Nurses' Notes, dated 01/04/11 through 02/17/11, lacked documentation to indicate the resident had a fall. During an interview on 02/17/11 at 10:50 a.m., the Reclaim Unit Manager, indicated the resident had not had a fall since 04/06/10. She indicated the fall assessment was not correct. 4. Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was admitted into the facility on 01/07/11. A) The Fall Risk Assessment, dated 01/07/11, indicated the resident was on an antihypertensive (Lopressor), a diuretic (Lasix), and a narcotic (Oxycontin) and the score for the medication area was three and the resident had no fractures. The total score of 10 or above represents a high risk for falls). The Fall Risk Assessment indicated if the resident takes three to four of the medications, the resident's score would be a four, and if the resident's fracture would have been marked, the	FORRECTION IDENTIFICATION NUMBER: A BUILDING S WING DOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6885 E 117TH AVE CROWN POINT, IN46307 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION 3. Resident #38's record was reviewed on 20/17/11 at 10.45 a.m. The resident's diagnoses included, but were not limited to dementia and hypertension. The resident's Nurses' Notes, dated 01/04/11 through 02/17/11, lacked documentation to indicate the resident had a fall. During an interview on 02/17/11 at 10:50 a.m., the Reclaim Unit Manager, indicated the resident had not had a fall since 04/06/10. She indicated the fall assessment was not correct. 4. Resident #22's record was reviewed on 02/16/11 at 9:10 a.m. The resident's diagnoses included, but were not limited to, hypertension and post right hip fracture. The resident was on an antihypertensive (Lopressor), a diuretic (Lasix), and a narcotic (Oxycontin) and the score for the medication area was three and the resident had no fractures. The total score on the Fall Risk Assessment indicated if the resident takes three to four of the medications, the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would be a four, and if the resident's score would b	DENTIFICATION NUMBER: 155637 A BUILDING DO

001198

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		A. BUI	LDING	nstruction 00	(X3) DATE S COMPL 02/23/2	ETED	
		100007	B. WIN		DDDEGG GITTY GTATE GID GODE	02/23/2	011
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
	OLAND CHRISTIAN			1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG		a 12, placing the resident at a	+	IAG	Dia teliate 1 y		DATE
	high risk for falls.	a 12, placing the resident at a					
	During an interview	on 02/16/11 at 10:40 a.m., the					
		ger, indicated the score on the					
		k should have been a four, not					
		cations and the resident's hip					
		been marked, which would ent's total score a 12 and					
		at a high risk for falls.					
		<u> </u>					
B) The resident's Urinary Incontinence Assessment, dated 01/11/11 indicated the resident							
	was continent of boy	wel and bladder.					
	The 3-Day Bladder	Data Collection record, dated					
	-	and 01/10/11 indicated the					
	resident was inconti	nent frequently.					
	5	00/1/6/11 + 10/20					
	_	on 02/16/11 at 10:30 a.m., (MDS) Nurse #3, indicated the					
		equently incontinent, but had					
		day MDS assessment. She					
	indicated she was ur	nsure why the nurse indicated					
		tinent when the resident was					
	frequently incontine						
		licated the bladder assessment					
	_	l after the three day voiding ed. She indicated the bladder					
	assessment was inco						
	3.1-31(a)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/23/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F0278 SS=A	resident's status. A registered nurse each assessment participation of heat assessment is. Each individual who the assessment maccuracy of that possible to a civil than \$1,000 for ea individual who willfully and k and false statement is subject to a civil than \$1,000 for ea individual who willfully and who willfully and the individual false statement in subject to a civil man \$5,000 for ea Clinical disagreem material and false Based on record facility failed to the Data Set) Assessible accurately, relate and pain manage.	must sign and certify that completed. To completes a portion of cust sign and certify the portion of the assessment. Ind Medicaid, an individual mowingly certifies a material and in a resident assessment money penalty of not more ch assessment; or an fully and knowingly causes to certify a material and a resident assessment is oney penalty of not more ch assessment. The total material and a resident assessment is oney penalty of not more ch assessment. The total material and interview, the ensure MDS (Minimum ments were completed do to missed diagnoses ment, for 3 of 24 and for accuracy of MDS's and completed do for accuracy of MDS's and completed do for accuracy of MDS's and complete do for accuracy of	F0278	F 2781. What is the correct action taken for the resident found to be affected by the deficient practice? a. Reside 66 MDS has been correct to reflect diagnosis of depressi Resident # 94 MDS has been correct to reflect diagnosis neurogenic bladder c. Resident # 141 MDS has been correctereflect that resident is receivered.	ent # on b. en dent # d to			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPI		ETED			
		155637	B. WIN			02/23/2	011	
		<u> </u>	B. ((11)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	8			117TH AVE			
CHICAG	OLAND CHRISTIAN	N VILLAGE		1	N POINT, IN46307			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE	
	Findings include	:	İ		pain management 2. How of	her		
					residents who have the pote	ntial		
	1. Resident #66's record was reviewed on				to be affected by the same			
		i.m. Resident #66's			deficient practice will be iden and what corrective action w			
		led, but were not limited			taken. a. The resident's curre			
					MDS 's will be reviewed by the			
		osteoarthritis, congestive			MDS nursing staff to ensure			
	heart failure, and	depression.			diagnosis and pain managen is coded correctly. 3. What			
	A Physician's Recapitulation Orders, dated 12/1/10 through 12/31/10, indicated				measures will be put into pla	ce or		
					what system changes will be			
	the resident had an order for Zoloft and a				made to ensure that the defi	cient		
	diagnosis of depression.				practice does not reoccur a. MDS team will be re-in-servi	and		
	diagnosis of dep	10351011.			with emphasis on i.	Jeu		
	A Quartarly Min	imum Data Set (MDS)			Assessment Protocol ii.			
	1 '	· · · · · · · · · · · · · · · · · · ·	Accuracy and completeness of assessment 4. How the corrective actions will be					
		ed 12/09/10, indicated the						
		l an antidepressant during						
	1	r since admission/reentry						
	_ ·	s. The MDS lacked		deficient practice will not reoccur i.e. what quality assurance will be				
	_	active diagnosis in the			put in place a. MDS/Care pla			
	last 7 days.				that are scheduled to be			
					completed during month will	be		
	During an interv	iew with MDS			audited by consultant nurse	nthe		
	Coordinator #3,	on 2/18/11 at 10:20 a.m.,			/designee monthly for six mo Findings will be reviewed by	nuis.		
	she indicated dep	pression should have been			Director of Nursing who will r	eport		
	checked on the N	MDS.			to Q/A if trends are identified			
					audits will be ongoing until			
	2. Resident #94'	's record was reviewed on			compliance is reached.			
		.m. Resident #94's						
	diagnoses includ	led, but were not limited						
	to, diabetes, hypertension, cardiovascular accident (CVA, stroke), and neurogenic bladder.							
	A CAA (Care Ar	rea Assessment), dated						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SU COMPLE		
ANDILAN	or correction	155637	- 1	A. BUILDING B. WING			111
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
1710	11/14/10, indicat		1	1710			Ditte
	· ·	urogenic bladder"					
	(unignosis) of neurogenic simulariii						
	An Admission M	IDS, dated 11/17/10,					
	_	c bladder as an active					
	diagnosis.						
	During an interview with MDS Coordinator #3, on 2/15/11 at 11:15 a.m., she indicated the neurogenic bladder diagnosis must have been missed. 3. Resident #141's record was reviewed						
	on 2/16/11 at 11:	20 a.m. Resident #141's					
	diagnoses include	ed, but were not limited					
	to congestive hea	art failure, hypertension,					
	and dementia.						
	A	I I I 9/26/10					
		ler, dated 8/26/10, /COD #3 (narcotic pain					
	reliever) one tabl	` •					
	Tenevery one tabl	et twice duity.					
	A significant cha	nge MDS (Minimum					
	_	nent, dated 11/26/10,					
	indicated Resider	nt #141 was not receiving					
	a scheduled pain	management regimen.					
	.	0/1//11 + 10 17					
	-	iew on 2/16/11 at 12:17					
	-	Care Nurse indicated the					
	resident was on s	was wrong as the					
	management.	enedule palli					
	management.						
	3.1-31(d)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPL	COMPLETED	
		155637	B. WING			02/23/20	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Œ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0280 SS=E	incompetent or oth incapacitated under participate in plant changes in care at the A comprehensive developed within to the comprehensive attending physicial responsibility for the appropriate staff in by the resident's representative; and revised by a team each assessment. Based on record facility failed to plans were devel to dental, restrain (support) hose, a status for 5 of 24 care plans in a sat #10, #22, #98, #5. Findings include 1. Resident #22' 02/16/11 at 9:10 diagnoses includ to, hypertension	care plan must be 7 days after the completion sive assessment; prepared hary team, that includes the n, a registered nurse with he resident, and other n disciplines as determined heeds, and, to the extent hitricipation of the resident, ly or the resident's legal d periodically reviewed and of qualified persons after review and interview, the hensure resident's care hoped and updated, related hits, dehydration, TED hoctivities, and cognitions hereidents reviewed for himple of 24. (Residents hereidents	F0:	280	F Tag 280 1. What is the corrective action taken for the resident found to be affected the deficient practice? a. The care plan for Resident # 22 w reassessed related to cognit status and activities. The resident care plan has been updated to reflect cognitive activity status. b. The care for resident # 10 was reviewe and TED hose was disconting from care plan. c. The care for resident # 125 was reviewed and updated to reflect self releasing belt which now is identified as a restraint. d. Resident #141 was reassed and care plan reviewed and updated to reflect the resident.	by ne vas tive and plan ed ued plan ved essed	03/25/2011

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIT	LDING	00	COMPL	ETED
		155637	A. BUI B. WIN			02/23/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF	PROVIDER OR SUPPLIEI	₹					
				1	117TH AVE		
CHICAG	OLAND CHRISTIAI	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
	the facility on 01	1/07/11.			be at risk for dehydration e.	The	
					care plan for resident # 98 w		
	The regident's C	are Area Assessment			reviewed and updated to refl		
					assist bid with oral hygiene.		
	1 ' '	y, dated 01/20/11,			How other residents who have		
	1	ident triggered activities			the potential to be affected b		
	and cognitive lo	ss/dementia. The CAA			same deficient practice will be identified and what corrective		
	indicated the facility was going to proceed with a care plan for both areas.				action will be taken. a. The		
					team will reviewed all reside		
					care plans to ensure that the		
					accurately reflect current sta		
	The resident's care plan, dated 01/27/11,				resident. 3. What measures		
	lacked documentation of a care plan for				be put into place or what sys	tem	
	the resident's co	gnitive loss/dementia and			changes will be made to ens	ure	
	activities.				that the deficient practice do	es	
					not reoccur i. Assessment		
	During an interv	riew on 02/16/11 at 10:30			Protocol ii. Accuracy and		
	"				completeness of assessmen	t iii.	
	1	Data Set (MDS) Nurse #3			Developing care plans from		
		vere no care plans for the			assessments 4. How the		
	resident's cognit	ion and activities.			corrective actions will be		
					monitored to ensure that the deficient practice will not reo		
	2. Resident #10	's record was reviewed on			i.e. what quality assurance w		
		a.m. The resident's			put in place a. All Care plan		
					are scheduled to be complet		
	1 -	led, but were not limited			during month will be audited		
	to, dementia and	diabetes mellitus.			consultant nurse /designee		
					monthly for six months. Find	ings	
	The resident's ca	re plan, dated 12/15/10,			will be reviewed by Director		
	indicated the res	ident had edema of the			Nursing who will report to Q/		
	bilateral lower e	xtremities The			trends are identified audits w	ill be	
		ided to apply TED			ongoing until compliance is		
	1 ^ ^	* * *			reached.		
	(support) hose as	s ordered.				l	
						l	
	1 -	Recapitulation Orders,				ľ	
	dated 02/11, lacked documentation to						
	indicate the resid	dent had an order for TED					
	hose						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
ANDILAN	OF CORRECTION	155637		LDING	00	02/23/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECT			
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
IAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	DEFECT (DATE
	During on intervi	iew on 02/15/11 at 10:35					
		#5 indicated there was					
		hose. She indicated					
		nted care plans and had					
	1	it for the resident.					
		it for the resident. 5's record was reviewed					
		20 a.m. Resident #125's					
	diagnoses included, but was not limited to dementia, cerebral vascular accident						
	(stroke) and osteoporosis.						
	A quarterly MDS	(Minimum Data Set)					
		d 12/17/10, indicated					
	· ·	as cognitively impaired.					
		DS assessment indicated					
		ired extensive assist for					
	1	and hygiene. The					
		ssessment was not					
	marked for a rest						
	marked for a rest	141111.					
	A Restraint Relea	ase Form, dated 1/24/11,					
		dent was unable to					
	release the self re						
		e facility would "now					
	consider this a re						
	tonorder timb a re	~ · · · · · · · · · · · · · · · · · · ·					
	Resident #125's o	care plans, dated 7/1/10					
	and revised 12/2	-					
		f a care plan for the					
		ease lap belt. A fall care					
		0 and revised 12/21/10,					
	* ·), self release alarming					
		r. There was a lack of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED					
AND PLAN	OF CORRECTION	155637		LDING		02/23/2	
		100007	B. WIN		DDDEGG CITY CTATE ZID CODE	02/20/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
		o indicate to staff,					
	interventions to be used now that the self release lap belt was a restraint.						
	During an intervi						
	a.m., the Restorative Nurse indicated						
	· ·	are plan completed for					
		seat belt now that it was					
	considered a restraint. 4. Resident #141's record was reviewed on 2/16/11 at 11:20 a.m. Resident #141's						
	diagnoses includ	ed, but were not limited					
	to congestive hea	art failure, hypertension,					
	and dementia.						
	"	nge MDS (Minimum					
	l ′	ment, dated 11/26/10,					
	indicated the CA	*					
	l '	nmary indicated the					
		oceed to care plan					
	Resident #141 fo	uenyaranon.					
	 Resident #141's a	care plans, dated 6/23/10					
	and revised 12/14	• .					
	documentation of						
	dehydration.						
	- 5						
	During an intervi	iew on 2/16/11 at 12:20					
	_	Nurse indicated there					
	1 *	an for dehydration for					
	Resident #141.	•					
	5. Resident #98'	s record was reviewed on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		155637	A. BUILDING B. WING	00	02/23/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE	
CHICAG	OLAND CHRISTIAN	N VILLAGE	l l	N POINT, IN46307	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
		.m. Resident # 98's			
		ed, but were not limited al, anemia, and diabetes.			
	_	ss Note, dated 2/1/11,			
		I hygiene HORRIBLE! eters) of generalized			
	`	needs assistance with			
	brushing her teet	h twice daily"			
	Residents #98's care plans, dated 1/1/11, lacked documentation of a care plan for the resident's oral hygiene.				
	During an intervi	iew on 2/15/11 at 10:15			
	_	dicated the resident did			
	not have a dental	care plan.			
	3.1-35(c)(1)				
	3.1-35(d)(2)(B)				
F0281 SS=D		ided or arranged by the professional standards of			
		ation, interview and	F0281	F 2811. What is the correcti	ve 03/25/2011
	· · · · · · · · · · · · · · · · · · ·	e facility failed to meet		action taken for the resident found to be affected by the	
	*	dards of quality, related 412) administering a		deficient practice? a. Reside 125 was reassessed for pair	I
				2/16/11 related to QMA	1 0(1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 02/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE **CROWN POINT. IN46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE administration of 650 mg of PRN (as needed) pain medication to a Tylenol a prn medication. b. QMA resident without the a nurse assessing the # 12 was counseled on the resident or authorizing the PRN pain administration of prn medication medication to be administered for 1 of 24 2. How other residents have the potential to be affected by the residents with pain medications in a same deficient practice will be sample of 24. (Resident #125 and QMA identified and what corrective #12) action will be taken. a. The problem was not related to other Findings include: residents but to this QMA not following policy and procedure. This concern wil lbe QMA #12 was observed on 2/16/11 at 12:40 p.m., addressed with all QMA's related to remove Resident #125 from the dining room to prn medication and take the resident to the nurses' station. OMA administration.3. What measures #12 was observed to administer 650 milligrams of will be put into place or what Tylenol (pain reliever) to Resident #125. The system changes will be made to QMA was not observed to tell a nurse of the ensure that the deficient practice resident's complaint of pain. does not reoccur a. All licensed staff will be re-educated as to role During an interview on 2/16/11 at the time of the of QMA related to prn medication observation, OMA #12 indicated she did not tell a and their responsibility of nurse of the resident's complaints of pain. overseeing QMA medication pass. b. All QMA were given a During an interview on 2/16/11 at 12:45 p.m., policy on prn medication MDS (Minimum Data Set) Coordinator #5 administration c. All QMA were indicated the QMA was supposed to ask the re-educated on their scope of nurses, so the nurses could assess the resident prior practice related to prn medication to giving the prn medication. 4. How the corrective actions will be monitored to ensure that the A professional resource, titled, "QMA deficient practice will not reoccur i.e. what quality assurance will be Scope of Practice: 412 IAC 2-1-9, put in place a. Rcc/Designee will reviewed on 02/22/11 at 9 a.m., indicated, conduct a weekly medication "...11) administer previously ordered pro pass for one month then bi re nata (PRN) medication only if weekly for one month and monthly for 4 month. These authorization is obtained from the audits will be conductedd on all facility's licensed nurse on duty..." shifts. Results of the observations will be reviewed by the Director of 3.1-35(g)(1)Nursing and trends will be

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 02/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE CROWN POINT, IN46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE reported to Q/A monthly for six months and on going if necessary. The services provided or arranged by the F0282 facility must be provided by qualified persons SS=D in accordance with each resident's written plan of care. F Tag 282 1. What is the Based on record review and interview, the F0282 03/25/2011 corrective action taken for the facility failed to ensure physician's orders resident found to be affected by were followed, related to medications, and the deficient practice? a. laboratory tests for 3 of 24 residents in a Resident # 10 -The physician was notified on 2/15/11 that insulin sample of 24 reviewed for following was not administered as ordered. physician's orders. (Residents #10, #23, resident had no adverse reaction and #94) and no new orders received. b. Resident #23 -The renal functions were not performed as ordered, Findings include: physician was notified and test was performed on 2/16/11. c. 1. Resident #10's record was reviewed on Resident #94 -The medications 02/15/11 at 9:30 a.m. The resident's (Prostat and Multi Vitaman diagnoses included, but were not limited)where not being administered per physician ordered. The to, dementia and diabetes mellitus. Physician was notified on 2/17/11 and new orders received. 2. How The Physician's Recapitulation Orders, other residents have the potential to be affected by the same dated 02/11, indicated an order, originally deficient practice will be identified dated 10/11/10, for Novolin (insulin) R to and what corrective action will be be given per sliding scale at 6 a.m., 11 taken, a. A chart audit was a.m., and 4 p.m. daily. The order indicated completed on all residents with for a blood sugar of 100-150 give 4 units orders for insulin coverage per sliding scale. Physician was of insulin and 151-200 give 6 units of notified if findings indicated. b. All insulin. Residents charts will be audited for lab orders and those results The resident's Glucose Monitoring are present and physician notified. c. All residents' Record, indicated on 02/08/11 at 4 p.m., physician orders will be audited the resident's blood sugar was 120 and a for accuracy and completeness line was drawn through the area for the and MAR and TAR reviewed to

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY OO COMPLETED						
AND PLAN	OF CORRECTION	155637	A. BUI	LDING	00	02/23/2		
		199637	B. WIN			02/23/2	011	
NAME OF	PROVIDER OR SUPPLIEI	₹		1	DDRESS, CITY, STATE, ZIP CODE			
CHICAG	OLAND CHRISTIAI	N VII I AGE		6685 E 117TH AVE CROWN POINT, IN46307				
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(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE	
IAU	ŧ	· · · · · · · · · · · · · · · · · · ·	-	IAU	ensure they match physician		DATE	
	1	en. The form indicated on			orders. 3. What measures w			
	_	m., the resident's blood			put into place or what system			
	1 -	nd a line was drawn			changes will be made to ens			
		for the insulin dose give.			that the deficient practice do			
		ted on 02/14/11 at 11			not reoccur a. A re-in-service			
	a.m., the residen	t's blood sugar was 193			Physician Orders and followi physician orders b. A	ng		
	and 4 units of in	sulin was given.			re-in-service will be presente	d to		
					Licensed staff on Blood Suga			
	The resident's Medication Administration				Policy /Sliding Scale Policy of	:. A		
	Record (MAR), dated 02/11, indicated on				re-in-service on lab ordering			
	02/08/11 at 4 p.m., the resident did not				following lab orders 4. How	the		
	receive insulin (circle around initials),				corrective actions will be monitored to ensure that the	,		
	there was a lack of documentation on the MAR to indicate the resident received 4				deficient practice will not reo			
					i.e. what quality assurance w			
		on 02/10/11 at 4 p.m.			put in place a. Medical recor			
		31 02/10/11 at 4 p.m.			will audit blood sugar sliding			
	D	: 02/15/11 10.50			documentation 3 days a wee			
	_	riew on 02/15/11 at 10:50			one month, then weekly for 1 month, every other week for			
		m Unit Manager indicated			month and then monthly for			
		e not given as ordered.			months . Medical records wil			
	_	view, RN #8, the nurse			report findings to Director of			
	1	0/11 at 4 p.m., indicated			Nursing who will then report			
	she had not give	n the insulin as ordered.			Quality assurance monthly. Quality assurance committee	. will		
					review findings monthly for s			
	2. Resident #23's 1	record was reviewed on			month and will recommend			
		The resident's diagnoses			whether monitoring needs to			
	included, but were				continue. b. RCC/designee			
	insufficiency and P	arkinson's Disease.			audit lab book daily and ched			
	A Physician's Order	r, dated 01/28/11 at 4 p.m.,			medical record to ensure rep present and physician has be			
		or renal function studies every			notified daily for one month .			
	three days.	22 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			times a week for one month,	-		
					weekly for one month, every			
	The resident's recor	d indicated the last renal			week for one month and mor	-		
	function in the resid	dent's record was on 02/07/11.			for two months .Audit finds w			
					presented to Director of Nurs when completed and the Dire			
	During an interview	v on 02/15/11 at 1:15 p.m.,			when completed and the Diff	-CIUI		

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 02/23/2	ETED
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR LPN #2 indicated the renal function studies 02/13/11. She indic company, and they was tudies on 02/13/11. On a week-end and the suppose to call the lass of the lab did not know the renal function terms.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) The resident should have had the sest done on 02/10/11 and sated she called the lab were faxing over the lab from id not draw the renal function She indicated 02/13/11 was the nurse who was working was tab, and the nurse did not call, ow they were suppose to draw st.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) of nursing will report findings the Q/A monthly for six mont All residents' physician order be audited monthly for accur and completeness and MAR TAR reviewed to ensure they match physician orders. Aud reports will be presented to Director of Nursing who will present findings to Q/A mont for six month. If indicated au will be ongoing	ato h. c. rs will racy and / it	(X5) COMPLETION DATE
	on 2/15/11 at 9:0 diagnoses include to, diabetes, hype	's record was reviewed 5 a.m. Resident #94's ed, but were not limited ertension, cardiovascular troke), and neurogenic					
	p.m., indicated P milliliters twice a	der, dated 2/11/11 at 4:45 rostat (supplement) 30 a day and change MVI applement) to MVI with					
	through 2/28/11, liquid 5 cc (cubic (feeding tube) qd initialed as given	cord, dated 2/1/11 indicated Multivitamin c centimeters) per g-tube (everyday) and was on 2/12, 2/13, 2/14 and not the multivitamin with					
	Record, dated 2/2	Record and Treatment 1/11 through 2/28/11, ation the Prostat was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED			
AND TEAN	or connection	155637	A. BUILDING B. WING		02/23/2011
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				117TH AVE	
	OLAND CHRISTIAN		CROW	'N POINT, IN46307	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
	ever given.				
	C				
	During an intervi	iew with LPN #9, on			
		a.m., she indicated the			
		with minerals was not			
	being given as or	dered.			
	2.1.25(.)(2)				
	3.1-35(g)(2)				
70040	A				
F0312 SS=D		unable to carry out activities ives the necessary services			
33-0	, ,	nutrition, grooming, and			
	personal and oral				
		review and interview, the	F0312	F 3121. What is the correct action taken for the resident	03/23/2011
		assist a resident who was		found to be affected by the	
	•	n ADLs (activities of		deficient practice? a. An ora	
		of 24 residents who ce with oral hygiene in a		assessment for resident #98 completed by the dentist or	* *
	•	idents. (Resident #98)		2/01/11.The dentist	·
	sample of 24 lesi	idents. (Resident #70)		recommendedin progress	
	Findings include	:		notes that resident was to receive assistance with brus	shing
	<i>G</i> 2			teeth twice daily. A new	·····9
	Resident #98's re	ecord was reviewed on		toothbrush and toothpaste w	•
	2/15/11 at 9:13 a	.m. Resident # 98's		dispensed. Certified Nursing Assistant Care Record was	
	diagnoses includ	ed, but were not limited		updated 2/15/11 it reflected	
	to, legally blind,	end stage renal, anemia,		dentist recommendation and	•
	and diabetes.			plan was updated on 2/15/17 indicate assist with oral hygical	
				twice daily. 2. How other	
		(Minimum Data Set),		residents have the potential	
	•	icated the resident's		affected by the same deficie practice will be identified and	
	cognition was int	•		what corrective action will be	
	extensive assist of	of one staff for personal		taken. a. All resident will be	

'		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155637	B. WIN			02/23/2	011
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			6685 E	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROWN POINT, IN46307			
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PREFIX	· `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	hygiene, transfer	s, and toilet use.			reassessed for oral care to		
					determine if assistance is		
	A Dentist Progre	ss Note, dated 2/1/11,			needed. Toothbrushes are replaced every thirty days. 3	1	
	_	hygiene HORRIBLE!			What measures will be put in		
		eters) of generalized			place or what system chang		
	· ·	needs assistance with			will be made to ensure that t		
					deficient practice does not		
	brushing her teet	n twice daily			reoccur a. A meeting with d will be scheduled to discuss		
	Residents #98's o	eare plans, dated 1/1/11,			improving assessment		
	lacked documentation of a care plan for the resident's oral hygiene with				communication related to or	al	
					hygiene. b. Nursing staff wi	ll be	
					re-in-serviced on oral care		
		the staff to assist the			assessment and procedure		
	resident in brush	ing her teeth.			will be documented on the a		
					assignment sheet if resident		
	During an intervi	iew on 2/15/11 at 10:15			needs assistance with oral c and frequency. 4. How the	are	
	a.m., LPN #11 in	dicated the resident did			corrective actions will be		
	not have a dental				monitored to ensure that the	e	
		ouro prum.			deficient practice will not rec		
	An undated CNA	Care Record, provided			i.e. what quality assurance v	vill be	
		_			put in place a. A follow up		
		15 a.m., by LPN #9 as			meeting will be scheduled w		
		I the resident required			the dentist to review change	s in	
	supervision and s	-			procedure that dentist will document recommendation	on	
	interview at the a	bove time with LPN #9,			physician order sheet rather		
	she indicated the	resident required			in progress notes. The nurse		
	assistance with h	er ADLs.			lbe responsible to note and		
					imp[lement physician orders	as	
	During an intervi	iew on 2/16/11 at 12:26			documented on ophysician		
		98 indicated "The CNAs			sheet. b. Oral assessment a		
	l * '				done daily by certified nursir	-	
	1 ^	my teeth this morning,			aide .An oral assessment wi completed monthly by licser		
	I -	lped me brush my teeth			nursing staff who will docum		
	was this morning	, "			and report abnormal findings		
					nurses notes. RCC/Designe		
	A facility policy,	dated 6/2/9, titled "Oral			audit monthly oral document	tation	
		ed "It is the policy of			for six months and will provi	de	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MI A. BUII B. WIN	LDING	00	(X3) DATE S COMPL 02/23/2 (ETED	
	PROVIDER OR SUPPLIER		•	6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE I POINT, IN46307	VE IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
F0322 SS=D	completed either staff members 3.1-38(a)(3)(C) 3.1-38(b)(1) Based on the com a resident, the fac resident who is fed gastrostomy tube treatment and serpneumonia, diarrh metabolic abnorm	prehensive assessment of lity must ensure that a d by a naso-gastric or receives the appropriate vices to prevent aspiration ea, vomiting, dehydration, alities, and ulcers and to restore, if			Director of Nursing for six mo and Director of Nursing will r findings to Q/A for six month	eport		
	review and i facility failed resident with tube (g-tube) received app related to ch	servation, record nterview, the d to ensure a n a gastrostomy (feeding tube) ropriate treatment ecking the g-tube nt and purging	F0	322	F 3221. What is the correctivaction taken for the resident found to be affected by the deficient practice? a. Reside 74 was assessed to determine that she had no ill effects as result of lack of checking g-placement prior to administe medication. 2. How other residents have the potential affected by the same deficient practice will be identified and what corrective action will be taken. a. All current g-tube residents have been identified	ent # ne a tube ring to be nt	03/25/2011	

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001198

If continuation sheet

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NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307 (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION (EACH CORRECTION SHOULD BE CROSS-REFERENCE OF TO THE APPROPRIATE COMPLETION COMPLETI	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE COMPLET		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCE OT OTHE APPROPRIATE COMPLETED COMPLETED TO THE APPROPRIATE COMPLETED COMPLETED TO THE APPROPRIATE COMPLETED TO THE CO		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTION COMPLEX PLAN OF COMPLEX		
CROSS-REFERENCED TO THE APPROPRIATE		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) DATE		
medications and fluids into the re-assessed and licensed nursing		
g-tube for 1 of 2 residents staff have been re-educated to g-tube policy and procedure. 3.		
reviewed with gastric tubes in a What measures will be put into place or what system changes		
sample of 24 (Resident #74) will be made to ensure that the		
deficient practice does not reoccur a. All licensed staff will		
Eindings include: be re-in-serviced on g-tube policy		
pass g-tube competency		
During an observation of the demonstration. b. All licensed staff will be re-evaluated yearly to		
morning modication page on ensure that g-tube policy and		
procedure are remember and		
passed. 4. How the corrective		
prepared Resident #74's actions will be monitored to ensure that the deficient practice		
medication. RIN #4 then will not reoccur i.e. what quality		
entered the resident's room assurance will be put in place. a. RCC/Designee will observe 3		
flushed the g-tube with 60 cc's monthly random g-tube		
(cubic centimeters) by purging medication passess. The medication passess will occur on		
(forcing-not allowing flow by each shift for six months.		
gravity) the water into the tube. RCC/Designees will report monthly findings to Director of		
RN #4 did not check the g-tube Nursing. The Director of Nursing		
for placement prior to purging will report findings to Q/A for six month.		
the water. RN #4 then		
continued to purge the		
resident's liquid potassium,		
followed by purging 60 cc of		
water, then purged the		
resident's acidophilus		
resident's actuophitus		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPL			
THETETAL	or connection	155637		BUILDING WING			02/23/2011	
NAME OF I	ADOLUDED OD GUDDU IED		D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
	PROVIDER OR SUPPLIER			1	117TH AVE			
	OLAND CHRISTIAN				N POINT, IN46307			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	(probiotic) n	nixed with water,						
	followed by	purging 60 cc's of						
	water. RN #	4 then purged 300						
	cc's of water	for the ordered						
	flush of the	g-tube.						
	During an in	terview on						
	02/15/11 at 7	7:20 a.m., RN #4						
	indicated she only checks							
		ments once a shift						
	1	done that at the						
		f her shift (worked						
	, , , , , , , , , , , , , , , , , , ,	She indicated they						
		the medications						
	and fluids in	to the g-tube.						
	• •	licy, dated 07/05,						
	titled, "Tube	Feedings",						
	received from	m the Director of						
	Nursing as c	urrent, indicated,						
	_	rce the solution						
	into the tube							
		low by gravity"						
		ion by gravity						
	A, "Medicat	ion Administration						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
		155637	B. WIN	IG		02/23/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	COMPLETION DATE
	per Gastric 7	Tube Competency"					
	form, receive	ed from the					
	Director of N	Nursing on					
	02/16/11 at 8	3:15 am., indicated					
	"5. Inserts	syringe into					
	feeding tube	and checks for					
	aspiration of	stomach					
	content6. If no gastric return,						
	then verifies placement with						
	stethoscope	and air in					
	syringeallo	ows medications to					
	flow per gra	vity with plunger					
	assist only a	s needed"					
	_	al resource, titled,					
	"Geriatric M						
		dated 04/07, page					
		ed, "check for					
		placement. 9.					
		c content for					
		lingflush tubing					
	using gravity	y flow"					
	3.1-44(a)(2)						
	$\begin{bmatrix} 3.1 & \pm \pm (a)(2) \end{bmatrix}$						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637			(X2) MUI A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPL 02/23/2	ETED
CHICAG	PROVIDER OR SUPPLIER	I VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	(X5) COMPLETION DATE
F0323 SS=D	environment rema hazards as is poss receives adequate devices to prevent Based on record facility failed to a adequate supervirorevent accidents transfer due to trawithout the indic assistance, which being fearful of femotional stress, reviewed who rettransfers in a same Findings included. Resident #22's re 02/16/11 at 9:10 diagnoses include to, hypertension a fracture. The resident facility on 01.	review and interview, the ensure a resident received sion and assistance to a related to an unsafe ensferring a resident ated amount of a resulted in the resident falling and causing for 1 of 24 residents equired assistance in aple of 24. (Resident #22) cord was reviewed on a.m. The resident's ed, but were not limited and post right hip dent was admitted into //07/11.	F03	23	F 323 1. What is the corrective actaken for the resident found affected by the deficient practice?a. A complete phy and psychological assessme was completed on Resident on 1/22/11. Physical therapy re-evaluated resident to determine if change was nein mode of transfer. Upon completion of assessment be physical therapy it was determined that residnet rea two assist. Aide care record was reviewed and updated include a change in mode of transfer.2. How other reside have the potential to be affee by the same deficient practivill be identified and what corrective action will be take All residents who are depen on staff for transfer will be re-assessed. The aide care record and care plans will be reviewed and updated as appropriate.3. What measu will be put into place or what system changes will be made ensure that the deficient practical care in the care of the correction of the care of the care record and care plans will be reviewed and updated as appropriate.3. What measu will be put into place or what system changes will be made ensure that the deficient practical care in the care of the care o	to be sical ent # 22 eded y quires rd o ents cted cce en.a. dent e	03/25/2011

li ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155637	B. WIN	IG		02/23/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		nmary score of 11			does not reoccura. Nursing will be re-serviced regarding		
	,	aired), and required			mobility and transfers and		
		nce of two or more staff			following aide care card and	care	
	for bed mobility	and transfers			plan.4. How the corrective		
					actions will be monitored to		
	The Resident Ass	sessment Protocol report,			ensure that the deficient pra		
	dated 01/17/11, i	ndicated the resident			will not reoccur i.e. what quassurance will be put in place		
	needed assistance	e of two staff for bed			Restorative Staff will perforn		
	mobility and tran	sfers.			weekly audits on residents v	vho	
					are dependent for transfer, t		
	A care plan, date	d 01/07/11, indicated the			determine mobility status an		
	_	story of a recent fall with			appropriate transfer is being followed.Audits will be done		
		re. The approaches			weekly for one month then b		
		fer the resident with two			weekly for one month and		
	assistance.	the resident with two			monthly for four months .Re		
	assistance.				of audits will be reviewed by		
	A Dhygiaal Thara	any avaluation note dated			Director of Nursing who will present findings to Q/A to		
	I	py evaluation note, dated			determine if audits are to continued after six month.		
	· ·	ed the resident required					
	maximum assista	ance with standing.					
		1 . 101/22/11					
	1	dated 01/22/11, no time					
	· ·	icated, "Care Concern					
		oes complete s/ (without)					
		sDenies any pain or					
	discomfort"						
		ent Reporting Form",					
	dated 01/22/11, i	ndicated the resident					
	made an allegation	on of rough handling					
	against former C	NA #7.					
	An investigation	note, dated 01/22/11,					
	indicated an Acti	vities Aide went to the					
	Director of Dieta	ry (Manager on duty) and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 02/23/2	ETED
NAME OF PROVIDER OR SUPPLIER		66	685 E 1	DRESS, CITY, STATE, ZIP CODE		
CHICAGOLAND CHRISTIAN	N VILLAGE		ROWN	POINT, IN46307	_	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
had a bad experied CNA's this morn Director of Dieta told her to get up resident stated shand the aide said her self (sic) and resident got herse positionand the (sic) arm which a pushed her hand was afraid of fall. An investigation 1:50 p.m., indicated the residentified former who took care of note indicated for removed from the indicated the resist she could not state her she could. The resident said, " to the wheel chaits said ok (resident placed a hand un me up to a standal knees gave out a for support. She slapped my hand me to quickly sit	en held on to the aides at that point the aide off her arm. Resident ling" note, dated 01/22/11 at ted the Nurse Manager esident and the resident CNA #7 as the CNA Ther that morning. The rmer CNA #7 was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUI	LDING	00	COMPL 02/23/2	
		100007	B. WIN			02/23/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	I VII I AGE		1	117TH AVE N POINT, IN46307		
					N 1 OIN1, IN40307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	brake (sic) my hi	·	-				
	orane (sie) my m	p ugum					
	An investigation	note, dated 01/22/11 at					
	1	ner CNA #7, indicated,					
	"she requested to get dress (sic) and up						
	_	wheelchair at 11:00					
		to stand up (arrow up)					
		her I would be right here					
		as standing on her left					
		ny left arm underneath					
		on the count of 3 we are					
		(arrow up). I counted to					
		up (arrow up). As I was					
		up (arrow up), she was					
		y uniform, extremely					
		lifficult for me to assist					
		ent name) she is going to					
	,	my uniform, I never					
	· ·	pushed or grabbed her					
	hand at any point						
	nana at any pomi	••••					
	 During an intervi	iew on 02/16/11 at 11:25					
	~	unit Manager indicated					
	l '	nad only worked as					
		'NA was not familiar					
	with the resident.						
	During an intervi	iew on 02/16/11 at 11:35					
	_	unit Manager indicated					
		ot have a Care Sheet,					
		hat help the resident					
	_	icated if the resident had					
		vould have told CNA #7					
		ired two people to assist					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/23/2011	
	PROVIDER OR SUPPLIER		6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
	the resident with 3.1-45(a)(2)	transfers.				
F0325 SS=D	assessment, the faresident - (1) Maintains accernutritional status, sprotein levels, unlecondition demonstrational problems and (2) Receives a the anutritional problems and observation of the factor	ation, record review and cility failed to ensure cian's recommendations o on and nutritional e given as ordered for a atinued weight loss, for 1 th weight loss in a atesident #84)	F0325	F Tag 325 1. What is the corrective action taken for the resident found to be affected the deficient practice? a. On 3/01/11 resaident # 84 was placed on hospice. On 3/15/dietician re-evaluated residerand orderes received to discontinue healthshake. On 2/16/11 a clarification order writtened to increase med pass 120 cc qd at 6:00am 2. How other residents have the	by 11 nt vas	

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OVPC11 Facility ID:

001198

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155637	B. WIN			02/23/2011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		6685 E	117TH AVE	
CHICAG	OLAND CHRISTIA	N VILLAGE		1	N POINT, IN46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE
			1		potential to be affected by th	e
	1 Pacidant #9/	's record was reviewed on			same deficient practice will l	
					identified and what corrective	e
		a.m. Resident #84's			action will be taken. a. The	
	diagnoses included, but were not limited				dietician will review all reside	ents
	to, osteoarthritis	, hypertension, hiatal			with a significant weight	
	hernia, and basa	l cell carcinoma.			loss.Dietician will document	on
					physican order sheet recoomendations as indicate	.4 3
	A care plan, date			What measures will be put in	* * .	
	A care plan, dated, 02/14/10, indicated the resident had significant weight losses.				place or what system change	
	The approaches indicated, "1. serve diet				will be made to ensure that t	
	1				deficient practice does not	
	per MD ordermonitor meal				reoccur a. Dietary	
	intakesmed pass 180 ml's (milliliters)				Director/designee will provide	
	• `	day)1/17/10 (sic 2011)			RCC's/Designee with a weel	dy
	Continue med p	as 180 mls qid and add			dietary consultation report	
	med pass 120 m	ls qd (daily)."			adressing the recommendat b. RCC/Designee will audit	ion.
	-				medcial records weekly for	
	The following w	veights were as follows, as			residents at risk for weight lo	ss to
	indicated on the	_			ensure dietary recommnedat	
	marcated on the	weight record.			have been followed.c.	
	11/10 154	1			RCC/Designee will report we	
		pounds			findings of audits to the Dire	
	11/17/10 149				of Nursing/Designee . Direct	
	11/24/10 143				Nursing /Designee will review weekly audits and report find	
	12/1/10 139				to Q/A monthly 4. How the	miyə
	12/8/10 135				corrective actions will be	
	12/15/10 133				monitored to ensure that the	,
	12/22/10 136				deficient practice will not reo	
	12/29/10 141				i.e. what quality assurance w	
	1/5/11 136				put in place a. Dietary Direct	
					/designee will provide RCC v	vitn
	1/12/11 132				dietary consultation reports weekly . b. RCC will	
	1/19/11 130				preform weekly medical reco	urd
	1/26/11 127				audits on residents with weigh	
	2/6/11 126				loss to ensure that dietary	'
	2/9/11 125				recommendation have been	
	2/17/11 123				followed . c. RCC will report	
					· · · · · · · · · · · · · · · · · · ·	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 02/23/2	LETED	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
IAU	A Nutritional Pro 1/17/11, indicate lossx 6 months wt is 132# shows weekmeal intal continues to drin QIDwill recompointing up) Med (resident already add 120 ml daily A Physician's ord 11:30 a.m., indic Pass 180 ml QID (every) day." A Medication Rethrough 1/31/11, 120 ml po daily and given as ord A Nutritional Pro 1/31/11, indicate shows a 14# loss changed to pure (by mouth) intak informed today to is involved in care eval. Further decorate wt loss likely to does not improved.	ogress Notes, dated d "sig (significant) wt - 34#/20% notedcurrent ing a 4# wt loss x 1 kes remain poor however k Med Pass 180 ml amend increase (arrow d Pass to 180 ml QID on since 12/14/10) and" der, dated 1/17/11 at ated "recommend Med o and Med Pass 120 ml q ecord, dated 1/1/11 indicated the Med Pass was started on 1/18/11	IAU	findings of audits to Direct Nursing /Designee weekl .Director of Nursing/Designeview weekly audits and findings to Q/A monthly findings to This will be ongoing the company of the compan	y gnee will report or six	DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	ETED	
		155637	B. WIN	G		02/23/2	011
	PROVIDER OR SUPPLIER		•	6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
	OLAND CHRISTIAN			l	N FOINT, IN40307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	1	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	dated January 20 of the resident's faconsumption for 1/3-1/15, 1/17-1/ for lunch on 1/1, 1/15, 1/16, 1/18- and 1/31 and for 1/5-1/9, 1/11, 1/1 1/26, 1/27, and	breakfast on 1/1, 19, 1/23, 1/30 and 1/31, 1/3-1/5, 1/7, 1/9-1/12, 1/20, 1/22, 1/23, 1/30, dinner on 1/1, 1/3, 2, 1/13, 1/16, 1/18, 1/20, /30. ew with LPN #13, on a.m., she indicated the n had "a lot of holes, they n." ogress Notes, dated d "Sig wt loss x6 2%Remains on pureed d Pass 180 ml QID and day. Meal intakes ofte being on ss per current orders est (estimated) caloric s. Per nursing note dated an's name) and (son's ent at this time-no on." continue /c med pass II have Dietary send					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155637		LDING	00	02/23/2	
		10001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/20/2	
NAME OF I	PROVIDER OR SUPPLIER			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
1710		ue Med Pass as per		mo	·		DATE
		send health shake on					
	meal trays."						
	Physician's telepl	hone orders written by					
	the Registered Dietician, dated 2/11/11,						
	lacked document	ation to indicate the					
	healthshake had l	been ordered as outlined					
	by the Registered	l Dietician.					
	A 3 6 11 71 75	1 1 . 10/11 1 1 1					
	A Medication Record, dated 2/11, lacked documentation of healthshakes being						
	given.						
	During an intervi	iew with the Dietary					
		6/11 at 12:11 p.m., she					
	•	on't give the healthshakes					
		The Dietician didn't					
	write an order for	r the healthshakes. We					
	will get an order	right now."					
		ecord, dated 2/1/11					
	"	indicated med pass 120					
		given at 6 a.m. It was					
	· -	iven on 2/11, 2/12, 2/13,					
		16 due to "Duplicate					
	order" written on	the Medication Record.					
	During an intervi	iew with LPN #9, on					
		.m., she indicated "I don't					
	_	vrote duplicate order, she					
	' '	getting the 120 ml					
		tion to the 180 ml four					
	times a day."						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637			(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMP 02/23/	LETED
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CO 117TH AVE N POINT, IN46307	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	2/16/11 at 12:20 receive a healths A facility policy Weight Loss", da current from the indicated, "statrisk for weight loprevention activity and provide an in	titled "Nutrition and ated 04/09, received as Director of Nursing, if will identify residents at less to assess and describe ties to address the risk, adividualized plan to significant unintended				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 02/23/2	ETED	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROWN	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0332 SS=D	medication error ra	nsure that it is free of ates of five percent or					
SS=D	Based on ob interview, are the facility for medication of than 5% for a sample of 2 and #74) and in a supplem (Resident #6 receiving medication and #1 operor in medication 21.95%. Findings incomplete the property of the p	servation, and record review, ailed to ensure a error rate of less 2 of 24 residents in 24 (Residents #68 d 1 of 13 residents dental sample of 13 do observed edications. Nine (9) dication on were observed oportunities for ication on. This resulted in a error rate of	F0	332	F 332 1. What is the correctivation taken for the resident found to be affected by the deficient practice? a. On 2/7,RN # 4 was verbally counse at the time of incident, about following medication administration policy with emphasis on following physic orders related to timeliness for Resident 74. b. On 2/15/11 f. 4 was verbally counseled at time of incident about following medication administration powith emphasis on following physician orders related to timeliness for Resident 68 c. 2/15/11 RN # 4 was verbally counseled at the time of incident about following medication administration policy with emphasis on following medication administration policy with emphasis on following physician orders related to timeliness for Resident 65 2. How other residents have the potential taffected by the same deficie practice will be identified and what corrective action will be taken. a. All residents have the potential to be affected and a nurses will be re-educated or medication pass regulation a facility policy. 3. What meas will be put into place or what system changes will be made ensure that the deficient practice since the deficient practice will be present of all licensed staff also to income and	distriction of the color of the	03/25/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAIN	OF CORRECTION	155637	A. BUII		00	02/23/2011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	V=/=0/=0 · ·
NAME OF F	PROVIDER OR SUPPLIER			1	117TH AVE	
	OLAND CHRISTIAN	N VILLAGE		1	N POINT, IN46307	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
	8:05 a.m., w	ith RN #4, the			QMA's b. A medication pass competency will be complete	
	following wa	as observed:			all licensed staff and QMA.'s	•
	A) At 7:10 a.m., RN #4 prepared Resident #74's			How the corrective actions will be monitored to ensure that the		
					deficient practice will not reo	ccur
					i.e. what quality assurance w put in place a. RCC/ Design	•
	1 1	which consisted of			will complete random medica	ation
	Potassium li				pass observations one on ea shift monthly ensuring differe	
		-			ed.	
	milliequivalent (MEQ) and acidophilus extra strength				for six month. Observations findings will be reviewed by	
	•	•			Director of Nursing monthly a	•
	4	RN #4 gave the			findings reported to Q/A for s month. Q/A will recommend i	
	medication a	at 7:20 a.m.			monitoring is to continue.	
		ne Medication				
	Administrati	ion Record (MAR),				
	dated 2/11, a	nt the time RN #4				
	was preparin	ng the medications,				
	the MAR inc	dicated the				
	medications	were scheduled for				
	6 a.m.					
	During an in	terview at the time				
	of the observation, RN #4 indicated she has an hour each way to give the medication, and the medication was given late.					
	me medicali	on was given fate.				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155637	- 1	LDING	00	02/23/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		CROW	N POINT, IN46307		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	The resident	's record was					
	reviewed on 02/15/11 at 8:05						
	a.m. The res	sident's diagnoses					
	included, but	t were not limited					
	· ·	and gastritis.					
	,						
	The resident's Physician's						
	Recapitulation	on Orders, dated					
	•	ated orders for					
	ŕ	nloride 20 MEQ,					
	^	at 6 a.m. and 6 p.m.					
		ilus extra strength					
	•	_					
		ree times daily at 6					
	a.m., 12 p.m	., and 6 p.m.					
	B) At 7:22 a	m DN #4					
	<i>'</i>	•					
	prepared Res						
		, which consisted					
	_	(hypothyroid					
	medication)	100 MCG					
	(micrograms	s) and Novolog					
	insulin 2 uni	ts. The resident					
	received the	medications at					
	7:35 a.m.						

li *		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV On COMPLETE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	A. BUI	LDING	00		COMPL 02/23/2	
		155057	B. WIN				UZIZSIZ	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STAT	E, ZIP CODE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN4630	7		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u> </u>	ID	,			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT	-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		CIENCY)		DATE
	The resident	's MAR, dated						
		ated the Synthroid						
	and Novolog insulin were							
	scheduled to be given at 6 a.m.							
	The medial and	la braalsfaat						
	The resident's breakfast was							
	served at 8 a.m.							
	Resident #68	B's record was						
	reviewed on	02/15/11 at 8:10						
	am The res	sident diagnoses						
		_						
		t were not limited						
	to, diabetes i							
	hypothyroidi	ism.						
	The resident	's Physician's						
	Recapitulation	on Orders, dated						
	_	ted an order for						
	Novolog to b	be given per sliding						
	_	nt of insulin given						
	`	blood sugar) at 6						
		• ,						
	a.m. and 4 p.m. and Synthroid 100 MCG daily at 6 a.m.							
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID:	OVPC11	Facility I	ID: 001198	If continuation sh	neet Pa	ge 61 of 99

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPI 02/23/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 6685 E	DDRESS, CITY, STATE, ZIP CODE		
	OLAND CHRISTIAN			CROWN	N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	C) At 7:40 a	a.m., RN #4					
	prepared Rea	sident #65's					
	medication, which included						
	Artificial tea	rs, citalopram 10					
	MG (milligr	ams)					
	(antidepress	ant), metoprolol 50					
	MG (blood p	oressure), vitamin					
	C 500 MG, A	Actos 30 MG					
	(blood sugar), Lasix 20 MG						
	(diuretic) two tablets, Klor-con						
	10 MEQ (po	otassium), aspirin					
	81 MG, lisii	nopril 20 MG					
	(blood press	ure), Tricor 145					
	MG (hyperli	pidemia), and					
	glipizide 5 N	AG two tabs (blood					
	sugar). RN	#4 removed the					
	resident's me	edication cards					
	from the car	t and placed each					
	medication,	except the					
	citalopram i	n the plastic					
	medication of	cup, which she					
	checked the	card and placed the					
	card of cital	opram to the side.					
	At 8:05 a.m.	, RN #4 indicated					
	there were 1	1 pills, then put the					
				ļ			<u> </u>

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER		J	STREET A 6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	medications	in applesauce					
	(there should	l have been 12					
	pills) and ga medication.	ve the resident her					
	While RN #4	4 was giving					
	Resident #65	her medication,					
	the resident	indicated the					
	medications	were late.					
	02/11 indica tears, citalop vitamin C, a	's MAR, dated ted the artificial bram, metoprolol, and glipizide were be given at 6 a.m.					
	the resident's given, RN #4	terview, right after s medications were 4 indicated she e she had not given m.					
	reviewed on	5's record was 02/15/11 at 8:15 sident's diagnoses					

∥ 155637		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE S COMPLE		
		A. BUII B. WIN			02/23/20		
NAME OF F	PROVIDER OR SUPPLIER		P. (711)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	OLAND CHRISTIAN				117TH AVE N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	N FOINT, IN40307		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	included, but	t were not limited					
	to, diabetes i	mellitus and					
	edema.						
	The resident	's Recapitulation					
	Physician's (Orders, dated					
	02/11, includ	led the following					
	orders:						
	Artifical Tea	rs one drop both					
	eyes twice d	•					
	•	AG 2 tablet at 6					
	• •	tablet at 6 p.m.					
		50 MG twice daily					
	•	00 MG twice daily					
		•					
	citalopram 1	o wid daily					
	A profession	al resource, titled,					
	•						
		ng Spectrum Drug					
		page xv, indicated,					
		timing of drug					
		on accounted for					
	43% of med						
	errorsusua	lly, a dose should					
	be given wit	hin 30 minutes					
	before or aft	er the time					

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/23/2011	
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			ST 66	85 E 117	RESS, CITY, STATE, ZIP CODE TH AVE OINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	specified in to 3.1-48(c)(1)	the order"					
F0368 SS=C	provides at least the times comparable community. There must be no between a substant breakfast the follow provided below. The facility must on the facili	eives and the facility hree meals daily, at regular to normal mealtimes in the more than 14 hours hital evening meal and wing day, except as ffer snacks at bedtime daily. If snack is provided at hours may elapse between ing meal and breakfast the esident group agrees to this hourishing snack is served. Ew, the facility failed to were offered snacks at 8 of 10 residents e group meeting. This esident interviewed about in a sample of 24 and 7 of 9 residents	F0368		F3681. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Reside 48 b. Resident # 47 c. Resider # 33 d. Resident # 53 e. Resident # 65 f. Resident # 87 h. Resident # 88 Resident # 87 h. Resident # 16 i. A snack cart will be used to deliver snacks to each room each residents listed above.	ent # dent 32 g. 100 o	03/25/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC11 Facility ID:

001198

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155637		LDING	00	02/23/2	
		100007	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	OZ/ZO/Z	
NAME OF I	PROVIDER OR SUPPLIE	₹		1	117TH AVE		
	OLAND CHRISTIAI	-		1	N POINT, IN46307		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ut bedtime snacks in a	+	IAG	How other residents have the	<u> </u>	DAIL
		mple of 13 (Residents			potential to be affected by th	-	
	1 **	65, #82, #87, and #100).			same deficient practice will l		
		ential to affect 140			identified and what corrective action will be taken. a. All	Э	
	_	al diet orders, who			residents have the potential	to be	
	resided in the he	· ·			affected so they will be include		
	Findings include	•			and will be offered utilizing the snack cart delivery. 3. What measures will be put into pla		
	D : 4 D :	1			what system changes will be made to ensure that the defi		
	1	dent Group meeting with			practice does not reoccur a.	510110	
		ntified by the Activity			Dietary personnel will be in		
		and oriented to person,			charge of delivering snacks		
	1 *	t all times, 8 of the 10			the snack cart at h.s. which was documented on the hs sn		
	,	ents #33, #47, #48, #53,			form. 4. How the corrective		
		nd #100) indicated the er them a bedtime snack at			actions will be monitored to		
					ensure that the deficient pra will not reoccur i.e. what qua		
	1 -	cated that someone used with a snack cart and			assurance will be put in place		
		edtime, but they had			Dietary manager/designee w	ill do	
		at. The residents were			10 random audits weekly by		
		ng on the Reclaim and the			asking residents if they have been receiving snacks. Dieta		
	Eden units of the	•			manager /Designee will pres	•	
	Luch units of the	ounding.			findings to the Q/A committe	e	
	During an interv	iew on 12/17/11 at 10			monthly for six month. Q/A w		
		ndicated the staff does not			recommend if audits need to continued.	be	
		ocument the bedtime			John Marie		
		ered and accepted.					
	January Word Office	noa ana acceptou.					
	3.1-21(e)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE S COMPL		
		B. WIN			02/23/2	011	
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE				6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR The facility must peresidents, or obtain described in §483. facility may permit administer drugs if under the general nurse. A facility must proviservices (including accurate acquiring administering of all meet the needs of The facility must e of a licensed pharmonistering of all pharmacy services. Based on record facility failed to accordance with related to the facility failed to accordance with related to the facility failed to accordance with related to the facility failed to	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) rovide routine and and biologicals to its in them under an agreement 75(h) of this part. The unlicensed personnel to is State law permits, but only supervision of a licensed vide pharmaceutical is procedures that assure the is, receiving, dispensing, and if drugs and biologicals) to each resident. Imploy or obtain the services macist who provides aspects of the provision of is in the facility. In review and interview, the dispose of medications in the standards of practice, fility being unable to charged resident's of 3 discharged ent #185) Tecord was reviewed on p.m. The resident's ed, but were not limited	F0	6685 E	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 4251. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Reside 185 had been discharged from facility and medication had been to be affected by the derive action to the part of the provided the provided the provided the provided the provided the potential to be affected by the same deficient practice be identified and what correct be identified and what correct be identified and what correct the provided that the provided the provided that the provided the provided that the potential to be affected by the same deficient practice be identified and what correct the provided that the provided tha	ve ent # om been but nad dents cted ce will ctive	(X5) COMPLETION DATE
				_===	action will be taken. a. All of resident have the potential to affected by this deficient pratherefore licensed staff will be re-educated on the importan completing the drug destruct disposition record at discharge.	o be ctice re ce of tion	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 02/23/2	LETED
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Orders, dated 01 was on the follow time of discharge multivitamin dai Prilosec (stomace (milligrams) ever Zocor (cholester every bedtime Colace 100 MG daily Geodon (antipsy capsules daily Geodon 20 MG Lopressor (blood daily Namenda (Alzhe MG twice daily Norvasc (cardiace Aspirin 81 MG Depakote (for becapsules every nat bedtime Ferrous Sulfate (Lasix 20 MG da Razadyne ER (A Cozaar (blood pr Acetaminophen as needed for fey Robitussin DM needed for cough	ly h medication) 20 MG ry morning ol medication) 80 MG (stool softener) twice chotic) 20 MG, two every evening d pressure) 25 MG twice eimer's medication) 10 e) 5 MG daily daily chaviors) 125 MG two norning and three capsules (iron) 325 MG daily ily clzheimer's) 16 MG daily ressure) 100 MG daily ressure) 100 MG daily essure) 100 MG daily every four hours every four hours as a cof documentation to			3. What measures will be p place or what system chang will be made to ensure that deficient practice does not reoccur a. An in-service will presented on drug destruction policy and procedure and pruse of forms. 4. How the corrective actions will be monitored to ensure that the deficient practice will not recive. What quality assurance will audit discharge records ensure that drug disposition records are present and completed for six month and report findings to Director of Nursing. The Director of Nursing. The Director of Nursing are to continue.	es the lbe on oper e occur will be ords to	
	Indicate the resid	lent's medication had					

ľ		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/23/2011
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET A 6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	During an intervia.m., the Reclaim she was not sure were. She indicar	iew on 02/18/11 at 10 In Unit Manager indicated where the medications ted there was no sition form for the			
F0463 SS=D	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation and interview, the facility failed to ensure residents' call lights were in working order in 2 of 12 bathrooms observed for call lights on 3 of 3 units in the facility. This had the potential to affect 3 residents in a supplemental sample of 13, who use bathrooms of rooms #I and #129. (/Resident #14, #103 and #104) Findings include: Observations during the environmental tour on 02/17/11 at 9:05 a.m. through 11:15 a.m., with the Executive Director, the Maintenance Director, The		F0463	F 4631. What is the corrective action taken for the resident found to be affected the deficient practice? a. Resident # 14 the call light will fixed and is functioning 2/17 b. Resident # 103 the call light was fixed and is functioning 2/17/11 c. Resident # 104 the light was fixed and is function 2/17/11 2. How other reside have the potential to be affected by the same deficient practice be identified and what correction will be taken. a. All resident have the potential that affected therefore all call light will be checked to ensure the they are in working order What measures will be put in	d by vas /11 ght ne call ining ents cted ce will ctive o be nts at 3.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155637 02/23/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6685 E 117TH AVE CHICAGOLAND CHRISTIAN VILLAGE CROWN POINT, IN46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE place or what system changes Housekeeping Director, and Maintenance will be made to ensure that the Person #16, the call light in the bathroom deficient practice does not of Room #I on the Haven Unit, did not reoccur a. Maintenance will activate when the call light was pulled. conduct 10 random call light checks weekly and correct as During an interview at the time of the approriate for four weeks.b. A observation, the Maintenance Director complete audit of call lights will be immediately notified another maintenance conducted monthly as part of staff member to come and fix the call preventative maintenance light. program. Findings will be documented on preventative maintenance log.c. At anytime a The call light in the bathroom of Room call light is idenified as not #129 on the Eden unit, did not activate functioning there is a current when the call light was pulled. The maintenance form that is forwarded to the maintenance Maintenance Director immediately called department. The Maintenance another maintenance staff member to fix Director reviews all work the bathroom call light. requisitions and assigns work orders, call light being a priority. d.Until maintenance can fixed call During the initial tour of the facility, on light the nursing staff will provide 02/14/11 at 11:05 a.m., LPN # 17, a bell for resident.4. How the identified resident #14 as being continent corrective actions will be of bowel and bladder. She indicated the monitored to ensure that the deficient practice will not reoccur resident required assistance with activities i.e. what quality assurance will be of daily living (ADLS). put in place a. The Maintenance staff will provided weekly call light During the initial tour of the facility on audits to the Maintenace Director who will report findings of audits 02/14/11 at 9:50 a.m., the Eden Unit to Administrator for one month. Manager identified Resident #103 and The Call loght preventive #104 as incontinent of urine. She maintain log will be reviewed indicated the residents required assistance monthly by the Maintenace Director and finding reproted to with ADLS. Q/A and thiis process will be ongoing. During an interview on 02/18/11 at 8:45 a.m., the Executive Director indicated the facility had no documentation to indicate

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637			(X2) MULTIPL	E CON	STRUCTION 00	(X3) DATE S COMPL	
		A. BUILDING B. WING 02/23/2011				011	
NAME OF PROVIDER OR SUPPLIER			668	5 E 1	DDRESS, CITY, STATE, ZIP CODE 17TH AVE		
	OLAND CHRISTIAN		CRO	NWC	POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0505 SS=E	the call lights we the preventative indicated the maid department monicall lights. He into of the call lights in the call lights. The call lights in the call lights	re being checked during maintenance rounds. He intenance and nursing tors the functions of the dicated an audit of 100% had been completed. romptly notify the attending ndings. review and interview, the promptly notify residents' oratory results for 5 of 24 ed for laboratory results of 23, #55, #66, #75, and	F0505		F 5051. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Reside #23: renal function study for 2/10/11 is now present in chab. Resident #55: BMP is in and physician has been notific. Resident #66: Keppa repin chart and physician has be notified d. Resident #75: CE and Chem. 7 is now in chart physician has been notified Resident #185: This was a discharged record prior to su 1/21/11 so we are unable to correct. 2. How other resident	ent chart ied. ort is een 3C and e. rvey	03/25/2011
	_	ency and Parkinson's			have the potential to be affect by the same deficient practic		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVPC11 Facility ID: 001198

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	A. BUILDING 00		COMPLETED	
		155637	A. BUII B. WIN			02/23/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹					
0111040	01 AND 011D10T1A				117TH AVE		
CHICAG	OLAND CHRISTIAI	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTION SHOULD BI CROSS-REFERENCED TO THE APPROPR			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Disease.				be identified and what correct	tive	
					action will be taken. a. All		
	A physician's or	der, dated 01/28/11,			resident charts will be review	ed to	
	1	er for renal function			ensure that lab orders have		
					completed as ordered, repor		
	studies every thr	ee days.			available in chart and physic has been notified 3. What	ian	
					measures will be put into pla	ce or	
	The resident's re	cord, indicated the last			what system changes will be		
	renal function st	udies had been completed			made to ensure that the defic		
		ere was no result for the			practice does not reoccur a.		
	 02/10/11 renal fi	unction studies in the			Re-in-service licensed staff of	n lab	
	resident's record				policies and procedures b.		
	Testuent's record	•			Re-in-service physician		
					notification policy and		
	_	iew on 02/15/11 at 1:15			procedures 4. How the corre	ective	
	p.m., LPN #2 in	dicated she notified the			actions will be monitored to ensure that the deficient pra	otico	
	lab and they wer	re going to fax the renal			will not reoccur i.e. what qua		
	function studies	over. She indicated she			assurance will be put in place		
	would notify the	resident's physician of			RCC /Designee will review la		
	the results.				orders, lab book and medica		
	the results.				record daily to ensure that la	bs	
	2 D 1 115.51				were drawn as ordered, resu		
		's record was reviewed on			are in chart and physician ha	ıs	
		0 a.m. The resident's			been notified for six months	41	
	diagnoses includ	led, but were not limited			.Results of audits will be repo		
	to, hypertension	and cardiomyopathy.			to Director of Nursing weekly findings will be reported to Q		
					monthly for six month. Q/A w		
	A physician's ord	der, dated 01/19/11,			determine if daily audits are		
	1 1 2	er for a CBC (complete			continue.		
		MP (basic metabolic					
	· · · · · · · · · · · · · · · · · · ·	,					
	1 * ' '	ytes), and Digoxin level					
	with the next lab	draw and weekly.					
	The resident's re	cord indicated the CBC					
	and Digoxin leve	el had been completed on					
	_	ab day). There was a lack					
	`	n to indicate the BMP had					

STATEMEN	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CC	ONSTRUCTION	(X3) DATE SU	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155637	B. WIN			02/23/20	11
					ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF F	PROVIDER OR SUPPLIER			6685 E	117TH AVE		
	OLAND CHRISTIAN				N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	-	DATE
	been completed v	with the other labs.					
	~	iew on 02/16/11 at 11:50					
	· ·	n Unit Manager indicated					
		en ordered and completed,					
	but the facility di	d not have the results.					
	She indicated she	e could pull it up on her					
	computer. She in	ndicated if the results					
	were not in the cl	harts, then the physician					
	was unaware of t	he results.					
	3. Resident #185	5's record was reviewed					
		30 p.m. The resident's					
		ed, but were not limited					
		and pulmonary vascular					
	disease.	and pullifoliary vascular					
	discase.						
	A physician's ord	ler, dated 01/11/11,					
	1 * *	er for a CBC to be					
	completed in the						
	completed in the	morning.					
	The regident's M.	ırses' Notes, dated					
		•					
		01/14/11, lacked					
		ne CBC had been					
	*	ne physician had been					
	notified of the re-	sults.					
		11 1 1					
	The resident's red						
		f the results of the CBC					
	ordered on 01/11	/11.					
		00/10/11 : 10					
	_	iew on 02/18/11 at 10					
	l '	n Unit Manager indicated					
	the CBC had bee	n completed, but the					

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO.	NSTRUCTION	(X3) DATE	LETED
AND FLAN	OF CORRECTION	155637		LDING	00	02/23/2	
		133037	B. WIN			02/23/2	2011
NAME OF I	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP CODE		
CHICAG	OLAND CHRISTIAN	N VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	. ,		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
	results had not be	een sent to the facility					
		n had not been notified of					
	the results.	indu not been notified of					
	the results.						
	 4 Resident #66'	s record was reviewed on					
		a.m. The resident's					
		ed, but were not limited					
	-	ler and dementia.					
	to, seizare aisore	or and demonta.					
	A physician's ord	der, dated 12/08/10,					
		ora levels (seizure					
	1	e completed weekly.					
		o compressed weekly.					
	The Kepra level	lab results, dated					
		11, and 02/16/11,					
	· ·	epra levels had been					
		the results were					
	"in-lab." There						
		n the resident's record to					
		e Kepra results were.					
	During an interv	iew on 02/18/11 at 10:05					
	_	ndicated the nurses'					
	· ·	owed up on the lab					
	results.						
	During an interv	iew on 02/18/11 at 10:15					
	•	ndicated she would call					
	l '	ne results. She indicated					
	1	d not been notified of the					
		he labs only come to the					
	facility.						
	5. Resident #75'	s record was reviewed on					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
ANDILAN	or correction	155637	A. BUII		00	02/23/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE	CROWN POINT, IN463		N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		7 a.m. The resident's	-				5.112
		ed, but were not limited					
	to, dementia and						
	•	Recapitulation orders,					
		eated an order for a CBC					
	,	etrolytes) to be completed					
	monthly.						
	The last CRC and	d Chem 7 in the resident's					
	record was dated						
	100010 Was autou	12/2 1/10:					
	During an intervi	iew on 02/17/11 at 2:37					
	p.m., LPN #15 in	dicated she would notify					
	the lab to check of	on the results of the					
	January CBC and	d Chem 7.					
	D	02/17/11 + 2.55					
	•	new on 02/17/11 at 2:55 adicated the CBC and					
	Chem 7 had been						
		results were not in the					
		ated the physician had					
	not been notified						
		nem 7 was received at the					
	J 1	n 02/17/11 at 2:44 p.m.					
	The CBC and Ch						
	completed on 01/	728/11.					
	3.1-49 (f)(2)						
	J.1-47 (1)(2)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING COMPLETED					
		155637	B. WIN			02/23/2	011
	PROVIDER OR SUPPLIER		•	6685 E	DDRESS, CITY, STATE, ZIP CODE 117TH AVE I POINT, IN46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0507 SS=E	record laboratory recontain the name a laboratory. Based on record facility failed to a laboratory report records for 5 of 2 labs in a sample of #55, #66, #75, ar Findings include 1. Resident #23's 02/15/11 at 11 and diagnoses include to, renal insufficing Disease. A physician's ordindicated an order studies every three The resident's records.	s were in the residents' 24 residents reviewed for of 24. (Residents #23, ad #185) : record was reviewed on m. The resident's ed, but were not limited ency and Parkinson's ler, dated 01/28/11, or for renal function	F0	507	F 5071. What is the correctivaction taken for the resident found to be affected by the deficient practice? a. Reside #23: renal function study for 2/10/11 is now present in chab. Resident #55: BMP is in and physician has been notific. Resident #66: Keppa repin chart and physician has be notified d. Resident #75: CE and Chem. 7 is now in chart physician has been notified Resident #185: This was a discharged record prior to su 1/21/11 so we are unable to correct. 2. How other reside have the potential to be affect by the same deficient practic be identified and what correct action will be taken. a. All resident charts will be review ensure that lab orders have completed as ordered, report available in chart and physician.	ent art. chart ied. ort is een 3C and e. rvey nts eted e will etive	03/25/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155637	1	LDING	00	COMPLETED 02/23/2011
		100007	B. WIN			02/23/2011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE	
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	has been notified 3. What	DATE
		ere was no result for the			measures will be put into pla	ce or
		nction studies in the			what system changes will be	
	resident's record.				made to ensure that the defi	cient
	Daning on interni	Same on 00/15/11 at 1.15			practice does not reoccur a. Re-in-service licensed staff of	on lab
	~	iew on 02/15/11 at 1:15			policies and procedures b.	il lab
	*	licated she notified the e going to fax the renal			Re-in-service physician	
	function studies	0 0			notification policy and	
	Tunction studies (JV C1.			procedures 4. How the corre actions will be monitored to	ective
	2 Resident #551	s record was reviewed on			ensure that the deficient pra	ictice
		a.m. The resident's			will not reoccur i.e. what qua	ality
		ed, but were not limited			assurance will be put in plac	
	_	and cardiomyopathy.			RCC /Designee will review la orders, lab book and medica	•
	to, hypertension	and cardiomyopathy.			record daily to ensure that la	l l
	Δ nhysician's ord	ler, dated 01/19/11,			were drawn as ordered, resu	l l
		er for a CBC (complete			are in chart and physician ha	as
		AP (basic metabolic			been notified for six months .Results of audits will be rep	orted
	· · · · · · · · · · · · · · · · · · ·	ytes), and Digoxin level			to Director of Nursing weekly	l l
	*	draw and weekly.			findings will be reported to C	
	With the next las	araw ara wooniy.			monthly for six month. Q/A w determine if daily audits are	
	The resident's red	cord indicated the CBC			continue.	
		el had been completed on				
	_	b day). There was a lack				
	`	n to indicate the BMP had				
		with the other labs.				
	•					
	During an intervi	iew on 02/16/11 at 11:50				
	a.m., the Reclain	unit Manager indicated				
		en ordered and completed,				
		d not have the results.				
	She indicated she	e could pull it up on her				
		ndicated if the results				
	were not in the cl	harts.				

NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DETICIENCIES (EACH DEPICIENCY MLS) BE PERCEPOR BY FULL (EACH DEPICIENCY). 3. Resident #185's record was reviewed on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and pulmonary vascular disease. A physician's order, dated 01/11/11, indicated an order for a CBC to be completed in the morning. The resident's Nurses' Notes, dated 01/12/11 through 01/14/11, lacked documentation the CBC had been completed and the physician had been notified of the results. The resident's record lacked documentation of the results of the CBC ordered on 01/11/11. During an interview on 02/18/11 at 10 a.m., the Reclaim Unit Manager indicated the CBC had been completed, but the results had not been sent to the facility. 4. Resident #66's record was reviewed on 02/18/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, seizure disorder and dementia. A physician's order, dated 12/08/10, indicated for Kepra levels (seizure	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		LDING	NSTRUCTION 00	(X3) DATE COMP 02/23 /2	LETED	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 3. Resident #185's record was reviewed on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and pulmonary vascular disease. A physician's order, dated 01/11/11, indicated an order for a CBC to be completed in the morning. The resident's Nurses' Notes, dated 01/12/11 through 01/14/11, lacked documentation the CBC had been completed and the physician had been notified of the results. The resident's record lacked documentation of the results of the CBC ordered on 01/11/11. During an interview on 02/18/11 at 10 a.m., the Reclaim Unit Manager indicated the CBC had been completed, but the results had not been sent to the facility. 4. Resident #66's record was reviewed on 02/18/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, seizure disorder and dementia. A physician's order, dated 12/08/10,				 STREET A	117TH AVE	I	
on 02/17/11 at 1:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and pulmonary vascular disease. A physician's order, dated 01/11/11, indicated an order for a CBC to be completed in the morning. The resident's Nurses' Notes, dated 01/12/11 through 01/14/11, lacked documentation the CBC had been completed and the physician had been notified of the results. The resident's record lacked documentation of the results of the CBC ordered on 01/11/11. During an interview on 02/18/11 at 10 a.m., the Reclaim Unit Manager indicated the CBC had been completed, but the results had not been sent to the facility. 4. Resident #66's record was reviewed on 02/18/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, seizure disorder and dementia. A physician's order, dated 12/08/10,	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	O BE	COMPLETION
medication) to be completed weekly.		3. Resident #185 on 02/17/11 at 1: diagnoses include to, hypertension adisease. A physician's ordindicated an order completed in the The resident's Nu 01/12/11 through documentation through documentation of the resident's readocumentation or ordered on 01/11 During an interval a.m., the Reclaim the CBC had bee results had not be 4. Resident #66's 02/18/11 at 9:30 diagnoses include to, seizure disord. A physician's ordindicated for Kepting and the condition of the results had not be seizure disord.	S's record was reviewed 30 p.m. The resident's ed, but were not limited and pulmonary vascular der, dated 01/11/11, or for a CBC to be morning. The resident's ed to be morning. The resident's ed to de CBC had been to the physician had been sults. The results of the CBC to be morning to the results of the CBC for the results of the CBC to the results o				

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STATEMEN	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	ONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155637	B. WIN			02/23/20)11
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			6685 E	117TH AVE		
	OLAND CHRISTIAN				N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DETERMET)	-	DATE
	The Kepra level	· · · · · · · · · · · · · · · · · · ·					
	· ·	11, and 02/16/11,					
	· ·	pra levels had been					
	· -	I the results were,					
	"in-lab". There v						
	documentation in	n the resident's record to					
	indicate what the	Kepra results were.					
	During an intervi	iew on 02/18/11 at 10:05					
	"	idicated the nurses'					
	l '	owed up on the lab					
	results.	owed up on the lab					
	resuits.						
	During an intervi	iew on 02/18/11 at 10:15					
	_	ndicated she would call					
	the lab and get th						
	5. Resident #75'	s record was reviewed on					
	02/17/11 at 11:27	7 a.m. The resident's					
	diagnoses includ	ed, but were not limited					
	to, dementia and						
	,						
	The Physician's I	Recapitulation orders,					
	1 *	cated an order for a CBC					
		ctrolytes) to be completed					
	monthly.	the system of the first the state of the sta					
	monuny.						
	The last CBC and	d Chem 7 in the resident's					
	record was dated						
	During an intervi	iew on 02/17/11 at 2:37					
	"	ndicated she would notify					
	_	on the results of the					
	January CBC and						
	January CBC and	a Chelli /.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155637	B. WING		02/23/2011
NAME OF F				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		6685 E		
	OLAND CHRISTIAN			N POINT, IN46307	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
IAU	During an interv p.m., LPN #15 in Chem 7 had beer indicated the lab chart.	niew on 02/17/11 at 2:55 Indicated the CBC and in completed. She results were not in the mem 7 was received at the in 02/17/11 at 2:44 p.m. mem 7 had been	IAG		DAIL
F0513 SS=D	record signed and other diagnostic so Based on record facility failed to were in the residof 24 residents re	le in the resident's clinical dated reports of x-ray and ervices. review and interview, the ensure residents' x-rays ents' clinical records for 2 eviewed for x-ray results 4. (Residents #55 and	F0513	F 5131. What is the correcti action taken for the resident found to be affected by the deficient practice? a. Resid #55: documentation is in cha and x-ray report is present be	lent art

AME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE SIMMARY STATEMENT OF DEFICIENCY TAG #185) Findings include: I. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's horizes a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and help were not in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's Forcord. She indicated the resident of the pelvis and hip x-ray were not in the resident's record. She indicated the resident of the pelvis and hip x-ray were not in the resident's record. She indicated the resident of the pelvis and hip x-ray were not in the resident's record. She indicated the resident in the resident of the pelvis and hip x-ray were not in the resident's record. She indicated the resident in the resident of the pelvis and hip x-ray were not in the resident's record. She indicated the resident in the resident of the pelvis and hip x-ray were not in the resident's record. She indicated the resident in the resident in the resident's record. She indicated the resident in the resident's record. She indicated the resident in the resident in the resident's record. She indicated the resident in the resident in the resident's record. She indicated the resident in the resident's record. She in the resident's r	STATEMEN	li ´			JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEBED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) #185) Findings include: 1. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/25/11 at 12 p.m., indicated an order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the x-rays had been completed and other was a lack of documentation in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the resident's record. She will be reported to Olar bin weekly for one month, then bi monitored to O.B. The month of the resident's record. She	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	DING	00	COMPLETED	
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICINCY MIST BE PERCEDED BY FULL TAG (EACH DEFICINCY MIST BE PERCEDED BY FULL TAG (EACH CORRECTION ACTION SHEEDED SHEEDED TAG) #185) Resident #185: this is a closed record and report was placed in closed record and report was placed in closed record. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident charts will be reviewed to ensure that x-ray have completed and order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been conflict			155637	1			02/23/2011	
CHICAGOLAND CHRISTIAN VILLAGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG RECULATORY OR LSC IDENTIFYING INFORMATION) #185) Findings include: 1. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/25/11 at 12 p.m., indicated an order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of documentation in the resident's record. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed as ordered. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record to indicate the x-rays had been completed as ordered. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She				B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
CHICAGOLAND CHRISTIAN VILLAGE IXA1ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG PREFIX TAG PRICE APPROPRIATE (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG PREFIX TAG PRICE APPROPRIATE (COMPLETION DATE) #185) #185) Resident #185: this is a closed record and report was placed in closed record 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident charts will be reviewed to ensure that Array have completed as ordered , report is available in chart and physician has been notified 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not record. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She	NAME OF F	PROVIDER OR SUPPLIER						
#185) #185) #186 Findings include: 1. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/25/11 at 12 p.m., indicated an order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She COMPLETION SOBSM-REFERENCE TO THE APPROPRIANE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE CROSS-REFERENCE TO THE APPROPRIATE CROSS-RESIDENCE TO A CROSS-REFERENCE TO THE SCHOLAR THE APPROPRIATE CROSS-RESIDENCE TO THE	CHICAG	OLAND CHRISTIAN	I VILLAGE					
#185) #185) #185) Resident #185: this is a closed record and report was placed in closed record 2. How other residents have the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. a. All resident charts will be reviewed to ensure that x-ray have completed as ordered greport is available in chart and physician has been notified. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She	(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
#185) #185) Findings include: 1. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/25/11 at 12 p.m., indicated an order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of indicated the resident had the x-rays completed and there were no x-ray reports for the pelvis and left hip in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She Resident #185: this is a closed record 2. How other resident was placed in closed record 2. How other resident was placed in closed record 2. How other resident was placed in closed record 2. How other resident was placed in closed record 2. How other resident's and less this is a closed record and report was placed in closed record 2. How other residents have the potential to be affected by the same deficient practice will be taken. a. All resident charts will be taken. a. All resident charts will be reviewed to ensure that x-ray have completed as ordered report was eviewed to ensure that x-ray have completed as ordered resident's Nurses' Notes, dated 01/25/11 at 12 What measures will be put into place or what system changes will be made to ensure that the deficient practice does not recocur i.e. what corrective actions will be put in place a. RCC /Designee will review x-ray orders to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC /Designee will review x-ray orders to ensure that the deficient practice will not reoccur i.e. what quality assurance will be put in place a. RCC /Designee will review x-ray orders to ensure that the deficient practice will not reoccur i.e. what quality a	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
Findings include: 1. Resident #55's record was reviewed on 02/16/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to, hypertension and cardiomyopathy. A physician's order, dated 01/25/11 at 12 p.m., indicated an order for an x-ray of the pelvis and the left hip. There was a lack of documentation in the resident's Nurses' Notes, dated 01/25/11 through 02/01/11 to indicate the resident had the x-rays completed as ordered. There was a lack of documentation in the resident's record to indicate the x-rays had been completed and there were no x-ray reports for the pelvis and left hip in the resident's record. During an interview on 02/16/11 at 11:50 a.m., the Reclaim Unit Manager indicated the results for the pelvis and hip x-ray were not in the resident's record. She	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		
the resident's record the resident had went for the x-ray. She indicated she would notify the facility's bus driver to see if she had taken the resident for the x-ray.	IAU	#185) Findings include: 1. Resident #55': 02/16/11 at 10:30 diagnoses include to, hypertension at the left to, hypertension at pelvis and the left there was a lack resident's Nurses through 02/01/11 had the x-rays coold the tresident's record been completed at reports for the peresident's record. During an intervial.m., the Reclaim the results for the were not in the resident's record. There was a lack resident's record been completed at reports for the peresident's record.	s record was reviewed on 0 a.m. The resident's ed, but were not limited and cardiomyopathy. der, dated 01/25/11 at 12 in order for an x-ray of the ft hip. of documentation in the 'Notes, dated 01/25/11 it to indicate the resident empleted as ordered. of documentation in the to indicate the x-rays had and there were no x-ray elvis and left hip in the fiew on 02/16/11 at 11:50 in Unit Manager indicated it pelvis and hip x-ray esident's record. She was no documentation in ord the resident had went it indicated she would o's bus driver to see if she		IAU	Resident #185: this is a close record and report was placed closed record.2. How other residents have the potential taffected by the same deficier practice will be identified and what corrective action will be taken. a. All resident charts be reviewed to ensure that xhave completed as ordered report is available in chart are physician has been notified. What measures will be put in place or what system change will be made to ensure that the deficient practice does not reoccur a. Re-in-service lice staff on follow-up of x-ray ordered to ensure reports are on chart how the corrective actions we monitored to ensure that the deficient practice will not reocite. What quality assurance we put in place a. RCC /Designwill review x-ray orders to enthat results are in chart and physician has been notified, Charts will be audited weekly ensure x-ray report is on chart one month, then bi weekly for month and then monthly for a months. Results of audits will reported to Q/A monthly for smonth. Q/A will determine if contents are incontents in the contents and physician has been notified, charts will be audited weekly ensure x-ray report is on charts and physician has been notified, charts will be audited weekly ensure x-ray report is on charts and physician had then monthly for a month and then monthly for a month and then monthly for smonthly and findings will be reported to Q/A monthly for smonth. Q/A will determine if the contents are contents and the monthly for smonth. Q/A will determine if the contents are contents and the contents are contents.	ed d in o be nt will ray nd d. to es ne nsed ders t. 4. till be ccur till be ee sure to rt for r one t t be ng ix	

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
AND PLAN	OF CORRECTION	155637	A. BUII		00	02/23/2	
		100007	B. WIN		ADDRESS SITE STATE SID CODE	02/20/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE			N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEF CHENCY)		DATE
		iew on 02/16/11 at 12:25					
	l * '	#1 indicated she had					
		t for the x-ray, before the fan's appointment. She					
		ay was done and the					
		e results. The Reclaim					
		dicated during the					
	1	sult was sent to the					
	· ·	e and the facility did not					
	have a copy of the						
	law care a copy or un						
	2. Resident #185	5's record was reviewed					
		30 p.m. The resident's					
		ed, but were not limited					
	to, hypertension	and pulmonary vascular					
	disease.						
	A physician's ord	ler, dated 01/11/11					
	indicated an orde	er for a chest x-ray.					
		es, dated 01/12/11 at 2					
	l * '	ne physician had been					
	notified of the ch	est x-ray results.					
	TEL 11 4	11 1 1					
	The resident's red						
		f the chest x-ray report					
	from 01/12/11.						
	During an intervi	iew on 02/17/11 at 2:15					
		n Unit Manager indicated					
	_	eport was not in the					
	resident's record.	-					
	1051dein 5 1000ld.						
	3.1-49(j)(4)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIP A. BUILDING B. WING		00	(X3) DATE S COMPL 02/23/20	ETED		
NAME OF P	ROVIDER OR SUPPLIER		l		DRESS, CITY, STATE, ZIP CODE			
CHICAG	OLAND CHRISTIAN	I VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
F0514 SS=E	each resident in according professional stand complete; accurate accessible; and sy. The clinical record information to identhe resident's asseand services provipreadmission scresstate; and progress Based on record facility failed to were complete an physicians orders and output record food consumption residents reviewed accurate medical #84, #98, #119, at Findings include 1. Resident #98 on 2/15/11 at 9:1	review and interview, the ensure medical records and accurate related to, a recapitulations, intake als, nurses' notes, and an record for 5 of 24 and for complete and records. (Residents #55, and #187)	F0514		F 5141. What is the corrective action taken for the resident found to be affected by the deficient practice? a. Reside 98 who is on fluid restriction was not filled out completely was re-in-serviced on I&O point and procedure b. Resident #187 who is on fluid restriction was not completed since it is closed record and we unable make corrections c. Resident 119 physician order was clarified albuterol is being given a ordered. d. Resident #84 For consumption was not complete in January and we are unable complete at this time. This resident is now on hospice are	nt# I&O staff blicy # I&O a e to t # fied as bod ted e to	03/25/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVPC11 Facility ID: 001198

If continuation sheet

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STATEME	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	, DDIG	00	COMPL	LETED	
		155637	A. BUI B. WIN	LDING		02/23/2	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	R		1				
CLUCAC	OLAND CUDICTIA	NI VIII I A C E			117TH AVE			
CHICAG	OLAND CHRISTIA	N VILLAGE		CROW	N POINT, IN46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	to, legally blind	, end stage renal, anemia,			refuses to eat but takes med			
	and diabetes.				5 times a day which docume			
					on MAR. e. Resident # 55 S	Santyl		
	A Physicians Or	ders Recapitulation, dated			order was clarified and	aa		
	I -	-			discontinued and new order written for waffle boots and	was		
	1 .	indicated the resident was			orthics have been discontinu	ıed		
	`	nillimeters) fluid			How other residents have			
	restriction.				potential to be affected by the			
					same deficient practice will			
	The resident's in	take and output record for			identified and what correctiv	е		
		lacked documentation of			action will be taken. a. All			
	1	take on the following			resident who are on Intake a			
		are on the following			Output charts will be review	ed to		
	dates:	11.0/5/11			ensure documentation to			
	7-3 shift on $2/6/$	11, 2/7/11, and 2/14/11.			complete. b. All resident's f			
					consumptions sheets will be reviewed to ensure that			
	During an interv	view on 2/15/11 at 10:23			documentation is complete.	α ΔΙΙ		
	a.m., LPN #11 i	ndicated the intake and			physician orders sheets will			
	1	hould be filled out."			reviewed for accuracy. And			
	output record s	nodia of inica odi.			correction made as needed.	3.		
	2 Danisland #10	2711			What measures will be put i	nto		
	1	7's closed record was			place or what system chang	es		
		7/11 at 1:55 p.m.			will be made to ensure that	the		
	Resident #187's	diagnoses included but			deficient practice does not			
	were not limited	l to, knee joint			reoccur a. Licensed profes	sional		
	replacement, hv	pertension, and difficulty			will be re-In-serviced on			
	in walking.				physician order policy and procedures b. Nursing staff	will		
					be re-in-service on I&O police			
	A physician's an	dor dated 1/2/11			procedure as well as food	oy and		
	1	der, dated 1/2/11,			consumption policy and			
		sident was on a 1200 ml			procedure and importance of	of		
	fluid restriction.				documentation 4. How the			
					corrective actions will be			
	The resident's in	ntake and output record for			monitored to ensure that the			
		acked documentation of			deficient practice will not rec			
	1 1	take on the following			i.e. what quality assurance v	vill be		
		are on the following			put in place a. The			
	dates:				RCC/designee will audit the			
	7-3 shift on 1/3/	11, 1/9/11, and 1/10/11.			Physician Orders, Intake/ou	tput		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 02/23/2	LETED	
	PROVIDER OR SUPPLIER			6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	3. Resident #119 on 2/17/11 at 11: diagnoses includito, failure to thriving failure, and cerebic (stroke). A Physician's Ordated February 2 following physic 1/21/11 "albuteroneb tx (breathing daily." 1/21/11 "albuteroneb tx every 4 hoshortness of breath order was marked duplicate. During an intervirum, the Restorative Nursician's order Restorative Nursician's order Restorative Nursician's order was marked duplicate. 4. Resident #84' 2/16/11 at 10:50 diagnoses includity.	D's record was reviewed 25 a.m. Resident #119's ed, but were not limited ve, congestive heart oral vascular accident ders Recapitulation, 011, indicated the ian's orders: ol/Ipratropium 1 vial per treatment) 3 times ol 0.083% neb 1 vial per ours prn (as necessary) th." This physician's d out with the word dew on 2/17/11 at 1:30 tive Nurse indicated the s were not the same. The e indicated the two duplicates. The e indicated she did not arse marked duplicate. s record was reviewed on a.m. Resident #84's ed, but were not limited hypertension, hiatal		IAU	and Food consumption were month, biweekly x 2 months monthly x 3 months. Direct Nursing /designee will reviet findings monthly and report QA committee monthly for months. The QA committee recommend any further act	s and or of w to the will	DAIE
	hernia, and basal	cell carcinoma.					

001198

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
AND PLAN	OF CORRECTION	155637	A. BUI		00	02/23/2	
		10001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/20/2	
NAME OF I	PROVIDER OR SUPPLIER			1	117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
IAG		Consumption Record,	-	IAU			DATE
	l	11, lacked documentation					
	of the resident's f						
	consumption for						
		19, 1/23, 1/30 and 1/31,					
	· ·	1/3-1/5, 1/7, 1/9-1/12,					
	· ·	1/20, 1/22, 1/23, 1/30,					
	'	dinner on 1/1, 1/3,					
		2, 1/13, 1/16, 1/18, 1/20,					
	1/26, 1/27, and 1/30. During an interview with LPN #13, on						
	2/18/11 at 10:55 a.m., she indicated the						
	food consumptio	n had "a lot of holes, they					
	should be filled i	n."					
	5. Resident #55's	s record was reviewed on					
	02/16/11 at 10:30	a.m. The resident's					
	diagnoses includ	ed, but were not limited					
	to, hypertension	and cardiomyopathy.					
	The resident's ad	mission orders, dated					
	01/17/11, indicat	ed an order for Waffle					
	Boots at bedtime	and Orthotic shoes					
	during the day.						
	Δ nhysician's ord	ler, dated 01/25/11,					
	1 * *	er to discontinue Santyl					
		tment) to the sacral					
	ulcer.	ament, to the sacrar					
	alcer.						
	The resident's Re	ecapitulation Physician's					
		11, and signed by the					
	· ·	d on 01/31/11, lacked					
		f the physician's order for					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ND IC	00	COMPI	LETED	
		155637	A. BUILI B. WING			02/23/2	011	
			B. WING		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	₹						
CLUCAC	OLAND CUDICTIAL	ALVIII LAGE	6685 E 117TH AVE					
CHICAGO	OLAND CHRISTIAI	N VILLAGE		CROWI	N POINT, IN46307			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ΤE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	the Waffle Boots, Orthotic shoes and the							
	discontinuation of	of the Santyl ointment.						
		21 4.14 2 4.1 10/1 21.101.101.101.						
	During on inter-	iew on 02/16/11 at 11:50						
	_							
		n Unit Manager indicated						
		d have been carried over						
	to the Recapitula	ntion Orders, dated 02/11.						
	3.1-50(a)(1)							
	3.1-50(a)(2)							
	3.1-30(a)(2)							
R0000								
10000								
	The following S	tate Residential findings	R00	000	N/A			
	_	e with 410 IAC 16.2-5.		,,,,,				
	are in accordanc	t with 410 IAC 10.2-3.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

OVPC11 Facility ID:

ility ID: 001198

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155637		(X2) MU A. BUII B. WIN	LDING	00	(X3) DATE: COMPL 02/23/2	ETED	
	PROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
R0036	resident 's physici representative who (1) a significant de physical, mental, o (2) a need to alter is, a need to disco treatment due to a commence a new Based on record facility failed to physician related 7 residents review sample of 7. (Resident #165's in 02/18/11 at 9:45 diagnosis include hypertension. The resident's we indicated the resident's weight pounds. The weight pounds. This wan inne months. During an intervial. The Wellnes indicated when the contract of the c	review and interview, the notify a resident's to a weight loss for 1 of wed for weight loss in a sident #165) record was reviewed on a.m. The resident's ed, but was not limited to, dent's weight was 137 ght record indicated the on 01/04/11 was 123 s a 10.2% weight loss in few on 02/21/11 at 9:40 as Care Coordinator ne weight loss had been tention on 02/18/11, she	RO	0036	R00361. What is the correct action taken for the resident found to be affected by the deficient practice? a. Physic was notified on 2/19/11 of tweight loss and the physici ordered weekly weights, entwice a day, lab work CBC, T3,T4,TSH, Total Protein, Albumin and Pre Albumin for resident #165. The Resider alert and oriented and responsible for self. 2. How residents have the potential affected by the same deficie practice will be identified an what corrective action will be taken. a. All assisted living residents will be reweighed determine a significant weight changes will be reported to physician and responsible pas needed. When a significat weight change has occurred assessment will be completed new service plan initiated if appropriate.3. What measure will be put into place or what system changes will be made ensure that the deficient pradoes not reoccur a. The Wellness Care Coordinator.	sian he an sure BMP, or to ther to be ent d e to ht arty ant d an ed a ares t de to octice	03/25/2011

001198

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 02/23/2	LETED
	PROVIDER OR SUPPLIER		STREET. 6685 E	ADDRESS, CITY, STATE, ZIP CODE 1117TH AVE IN POINT, IN46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE
	A Physician's Co 02/19/11, indicat orders, "1. weekl (complete blood Basic Metabolic T4, TSH (thyroid	oncern Report, dated ed the following new by weights 2. CBC count) with differential, Panel (electrolytes), T3, d tests), total protein, cumin. 3. Ensure (dietary		meet with medical direct monthly to review weigh changes. The Wellness coordinator will documed meeting outcome on consection of service plan. significant weight changoccurred an assessment completed a new service initiated if appropriate. Accorrective actions will be monitored to ensure that deficient practice will not i.e. what quality assuran put in place Service plan audited by nurse monthly will be reviewed by Direct Nursing monthly times 3 and then quarterly for 6 Findings will be reported quarterly for six month	at the nament when a se has se will be se plan How the the reoccur ce will be se will be se will be so will be so will settor of months months.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		DING	NSTRUCTION 00	(X3) DATE S COMPL 02/23/20	ETED		
	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307		
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR (e) Following complete facility, using appropriate appropriate services to be provided services to be provided services to be provided services of resident shall be a (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services of and revised as applete resident and fact and services are appleted as a service plan resident upon required. (3) The agreed upsigned and dated of the service plan resident upon required. (A) No identification services provided subsequent to the need for a change. (5) If administration provision of reside both, is needed, a involved in identification the services to be a seed on record and facility failed to the resident were resident's services.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Deletion of an evaluation, the opriately trained staff entify and document the wided by the facility, as ffered to the individual ppropriate and discussed by acility as needs or desires of acility or the resident may colan review. On service plan shall be by the resident, and a copy shall be given to the uest. In and documentation of is needed if evaluations initial evaluation indicate no in services. In of medications or the notial nursing services, or licensed nurse shall be cation and documentation of provided. Teview and interview, the ensure services offered to a documented on the plan related to			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) R 2171. What is the correcti action taken for the resident found to be affected by the deficient practice? a. The service plan for resident # 15	ve	(X5) COMPLETION DATE 03/25/2011
	2 of 7 residents re	gement and mobility for eviewed for service plans (Residents #158 and			was reviewed and updated of 2/21/11 to reflect self medical administration, and mobility. The service plan for Residen reviewed and updated 2/21/2 reflect self medication administration. 2. How other	n tion b. t 178 11 to	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637 A. BUILDING B. WING			(X3) DATE S COMPL 02/23/2	ETED				
	PROVIDER OR SUPPLIER		668	35 E 1	DDRESS, CITY, STATE, ZIP CODE 17TH AVE POINT, IN46307			
(X4) ID PREFIX TAG	(4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL			IX G	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) residents have the potential t affected by the same deficier practice will be identified and	o be	(X5) COMPLETION DATE	
	1. Resident #159's record was reviewed on 02/21/11 at 8:35 a.m. The resident's diagnoses included, but were not limited to, muscle weakness and osteoarthritis. The resident's Recapitulation Physician's Orders, dated 02/11, indicated the resident could self administer her medications after the staff sets up the medications for the week. The Self-Administration of Medications			what corrective action will be taken. a. The assisted living residents will be reassessed and service plan updated to reflect current status of medication administration and mobility. 3. What measures will be put into place or what system changes will be made to ensure that the deficient practice does not reoccur a. The licensed staff will be re-in-service on the plan policy and procedure b. The licensed staff will be				
	Assessment, date resident could sa medications. The resident's,Se dated 11/12/10, i required maximu medication mana. The form indicat supervision-Assi	ed 11/12/10, indicated the fely self administer her ervice Plan Assessment, indicated the resident am supervision for agement administration. The edge of the edge	licensed staff will be re-in-serviced on the se medication administration of the re-in-serviced on the se medication administration of the re-in-serviced on the se medication administration of the corrective at the medication administration of the semicondarial medication administration of the medication of the medication of the medication of the medication administration of the medication of the medication administration of the medication administration of the medication administration of the medication of the medication of the medication administration of the medication administration of the medication of the m			s will the ccur ill be by will or		
	management or r distributionNec coordination of s routine instruction the comments se Care Coordinato	_						

		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155637	B. WIN	G		02/23/20	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CLUCAC	OLAND CUDICTIAN	17/11/405		1	117TH AVE		
	OLAND CHRISTIAN				N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
IAG		n Assessment, dated	+	IAG			DATE
	l '	ed the resident required					
	· ·	bulation, mobility and					
		rea on the comments					
	section was left b						
	section was left t	Julik.					
	During an interview on 02/21/11 at 8:40						
	~	ss Care Coordinator					
	· ·	vere no comments written					
	on the service pla						
	p						
	2. Resident #178's record was reviewed on 02/21/11 at 8:45 a.m. The resident's						
	diagnoses includ	ed, but were not limited					
	~	sm and legally blind.					
	The resident's Re	ecapitulation Physician's					
	Orders, dated 02	/11, indicated the					
	resident could se	lf administer her					
	medications after	r the staff sets up the					
	medications for t	he week.					
	The Self-Admini	stration of Medications					
	Assessment, date	ed 09/23/10, indicated the					
	resident could sa	fely self administer her					
	medications.						
	The resident's M	AR dated 02/11,					
		ff at the facility were					
		ident's medication for a					
	week at a time ar	nd the resident was self					
	administering the	e medication after they					
	were set up.						

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/23/2011
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	dated 09/26/10, is required assistant mobility and transection indicated recent fall. Unables self if an emerger lacked document service would be and who would putter of the control of t	The comments section given per staff. Uses Description of the distribution of the dis			
R0244	scheduled adminis	doses for more than one (1) stration is not permitted.	R0244	F 2441. What is the correct	ve 03/25/2011
		, , , , , , , , , , , , , , , , , , , ,		ļ	

001198

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE	
CHICAGOLAND CHRISTIAN VILLAGE CROWN POINT, IN46307	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) I	(X5) OMPLETION DATE
interview, the facility failed to ensure not more than 1 scheduled medication administration was prepared related to the facility setting up medications for a week for 3 of 4 residents who self administer medications in a sample of 7. (Residents #159 #178, and #184) Findings include: During an observation on 02/18/11 at 9:05 a.m., Resident #178 was in her apartment sitting in her recliner. The resident indicated, during the observation, she self administers her own medications after the staff set up her medication for the week. During an observation on 02/18/11 at 9:20 a.m., resident #184 was sitting in her room. There was a plastic medication container marked with the days of the week on the resident's counter in her kitchen with loose medication stored in the plastic container. During an observation on 02/18/11 at 9:25 a.m., resident #159 was sitting in her wheelchair in her room. The resident indicated, during the observation, she self wheelchair in her room. The resident indicated, during the observation in the plastic container marked with the days of the week on the resident's counter in her wheelchair in her room. The resident indicated, during the observation, that she takes her own medications after the facility sets up her medications for the week. 1. Resident #184's record was reviewed action taken for the effection type and it was determined that facility would administer medication for this resident. Physician orders were received to discontinue self administration of medication to this resident. Physician orders were received to discontinue self administration of medication c. On 2/18/11 Resident 184 (hospice) was reassessed and it was determinised that facility would administer medication to this resident. Physician orders were received to discontinue self administration of medication to this resident. Physician orders were received to discontinue self administration of medication to c. On 2/18/11 Resident 184 (hospice) administer medication to c. On 2/18/11 Resident 184 (hospice) administe	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155637	B. WIN	IG		02/23/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
TWINE OF I	NO VIDER OR SOTTEEL	•		1	117TH AVE		
CHICAG	OLAND CHRISTIAN	N VILLAGE		CROW	N POINT, IN46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	on 02/21/11 at 8:	:10 a.m. The resident's			that the deficient practice do		
	diagnoses included, but were not limited				not reoccur a. Assisted Livir policy and procedure were	ıg	
	to, congestive he	eart failure and pulmonary			reviewed and updated to ens	sure	
	hypertension.				compliance with Indiana Stat		
					regulations. b. Staff were		
	The resident's Ph	nysician's Recapitulation			re-in-serviced on assisted liv	ing	
		/11, indicated the resident			policy and procedure on medication administration an	d	
	could self-admin				Indiana state regulations c.	-	
	medications.				facility letter will be issued to		
					residents/family regarding		
	The Self-Administration of Medications Assessment, dated 09/22/10, indicated there were no concerns with the resident				medication policies and		
					procedure related to Assisted		
					Living. 4. How the corrective actions will be monitored to	;	
					ensure that the deficient pra	ctice	
	1 -	ministration of the			will not reoccur i.e. what qua		
	medication.				assurance will be put in place		
					Medication Administration pe	olicy	
	The resident's M	edication Administration			and procedure which are in		
	Record (MAR) of	lated 02/11, indicated the			compliance with Indiana state regulations will be reviewed		
	staff at the facilit	ty were setting up the			Q/A committee and signed for		
	resident's medica	ation for a week at a time			approval. RRC/Designee will		
	and the resident	was self administering			perform random weekly		
	the medication a	fter they were set up.			medication pass audits for or		
					month, bi weekly for one mo		
	2. Resident #178	8's record was reviewed			and monthly for four months will present audits to Director		
		:45 a.m. The resident's			Nursing who will report finding		
		led, but were not limited			Q/A for six months.	J	
	1 ~	sm and legally blind.					
	io, ny pomyroidis	on and regardy office.					
	The resident's Ra	ecapitulation Physician's					
		/11, indicated the					
	· ·	elf administer her					
		r the staff sets up the					
	medications for	the week.					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	
AND PLAIN	OF CORRECTION	155637	A. BUII		00	02/23/20	
		100001	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/20/2	
NAME OF F	PROVIDER OR SUPPLIER				117TH AVE		
CHICAG	OLAND CHRISTIAN	I VILLAGE		1	N POINT, IN46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		stration of Medications		IAU			DATE
	Assessment, dated 09/23/10, indicated the resident could safely self administer her medications.						
	The resident's M.	AR, dated 02/11,					
		f at the facility were					
		ident's medication for a					
		nd the resident was self					
	administering the medication after they						
	were set up. 3. Resident #159's record was reviewed						
		35 a.m. The resident's					
		ed, but were not limited					
	_	ness and osteoarthritis.					
	The resident's Re	ecapitulation Physician's					
	Orders, dated 02/	/11, indicated the					
	resident could se						
		the staff sets up the					
	medications for t	he week.					
	The Salf Admini	stration of Medications					
		ed 11/12/10, indicated the					
	l '	fely self administer her					
	medications.	201, Soil wallilliotte liet					
	The resident's M.	AR, dated 02/11,					
	indicated the staf	f at the facility were					
	setting up the res	ident's medication for a					
	week at a time ar	nd the resident was self					
	_	e medication after they					
	were set up.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/23/2011		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	a.m., the Wellnes indicated a nurse medication for si	iew on 02/18/11 at 9:35 as Care Coordinator a from the facility sets up ix residents. She ad been doing this since					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155637	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING B. WING (X3) DATE SU COMPLET 02/23/20		ETED		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 6685 E 117TH AVE CROWN POINT, IN46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL PEGLIL ATORY OF LSC IDENTIFYING INFORMATION)		1	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
R0356	OLAND CHRISTIAN VILLAGE SUMMARY STATEMENT OF DEFICIENCIES		R03		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		03/25/2011

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155637		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/23/2011		
NAME OF PROVIDER OR SUPPLIER CHICAGOLAND CHRISTIAN VILLAGE			6685 E	ADDRESS, CITY, STATE, ZIP CODE 117TH AVE N POINT, IN46307	-	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
	file available. During an interv Wellness Care C	iew on 02/18/11, the oordinator indicated the nave an emergency file.		developed to include emer file (which includes resider Independent Admission Re and photo of resident).4. It corrective actions will be monitored to ensure that the deficient practice will not resident practice will not resident practice will not resident practice will not resident quality assurance put in placea. Emergency be reviewed semi-annually determine if updates are needed.b. Resident Care Coordinator will audit emer file semi-annually and report findings to Director of Nursing will preserved findings to Q/A semi-annually for 1 year.	the ecord How the he ecocur will be file will to rgency ort	